Manual:	Medical Staff Corporate Policy and Procedure	Origination Date:	03/23/2022
		Approval Date	04/05/2022
Title:	Medical Staff Bylaws	Next Periodic Review:	04/05/2025
		Owner:	Jodie Franzen
Duncan Regional Hospital, Inc., d/b/a DRH Health policies apply to Duncan Regional Hospital, Jefferson County Hospital and Rural Health Clinics, Solutions Specialty Clinics and Practice Management, and Advanced Medical Supply.			

Bylaws

of the

Medical Staff

of

DRH Health

DRH HEALTH
MEDICAL STAFF BYLAWS
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PREAMBLE

WHEREAS, Duncan Regional Hospital, Inc., d/b/a DRH Health owns and operates Duncan Regional Hospital (DRH) as a general acute care sole community hospital operated by DRH Health, a not for profit corporation organized under the laws of the State of Oklahoma, which also operates an integrated system of delivering physician, hospital and related health services to the community DRH Health serves; and,

WHEREAS, Duncan Regional Hospital, Inc., d/b/a DRH health owns and operates Jefferson County Hospital (JCH) as a general acute care critical access hospital affiliated with and administered by DRH Health; and, WHEREAS, the physicians, dentists and podiatrists in the community DRH Health serves may apply for permission to provide patient care at more than one affiliated location within DRH Health; and,

WHEREAS, DRH Health and the members of its medical staff who provide services at DRH and JCH desire to form a single Medical Staff; and,

THEREFORE, the physicians, dentists and podiatrists practicing at DRH Health are hereby appointed and organized by the Governing Body into a single medical staff in conformity with these Bylaws and the Bylaws of the Governing Body, and shall be known as the Medical Staff of DRH Health, hereinafter collectively referred to as the "Medical Staff."

The Medical Staff shall be composed of physicians, dentists and podiatrists. In addition, there shall be an allied health professionals division that includes individuals granted clinical privileges, but who are not members of the Medical Staff.

DEFINITIONS

Whenever used in these Bylaws, the terms listed below shall have the meaning stated herein unless the context should clearly require otherwise. Such meanings shall be equally applicable to the singular and plural forms, and where applicable, to the masculine and feminine genders of the terms defined or used herein.

1. **"Act"** shall mean the Health Care Quality Improvement Act of 1986, Section 401 of Public Law 99-660, codified at 42 U.S.C. §11101 et. seq., and the rules and regulations promulgated thereunder, as amended from time to time, or any successor legislation conferring comparable privileges and immunities.

2. **"Adversely affecting"** shall mean the reduction, restriction, suspension, revocation, denial or failure to renew Clinical Privileges at the Hospital or membership in the Medical Staff.

3. **"Allied Health Practitioner"** or "AHP" shall mean an individual other than a licensed Physician, Dentist, or Podiatrist whose patient care activities require their authority to perform specified patient care services be processed through Medical Staff channels or with involvement of Medical Staff representatives. An AHP is not considered a member of the Medical Staff. An AHP is subject to the policies and procedures governing AHPs.

4. **"Appellate Review Body"** shall mean the group designated under the Fair Hearing Plan to hear a request for appellate review filed and pursued by an applicant or Medical Staff member.

5. **"Applicant"** shall mean any practitioner who has submitted a completed application for initial appointment to the Medical Staff.

6. **"Board Certified"** shall mean having successfully completed all requirements and be recognized as such by a specialty board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) or an equivalent organization in a country eligible for licensure through endorsement of current license by the Licensure Board.

7. **"Board Eligible"** shall mean having successfully completed the requirements and being eligible to take the certifying exam of a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association or an equivalent organization in a country eligible for licensure by endorsement of current license by the Licensure Board.

8. **"Board of Directors"** or "Governing Board" shall mean the Board of Directors of Duncan Regional Hospital, Inc., d/b/a DRH Health.

9. **"Bylaws"** or "Medical Staff Bylaws" shall mean the Bylaws of the Medical Staff of DRH Health., and the following related manuals: (i) Medical Staff Fair Hearing Plan; and (iii) Medical Staff Rules and Regulations.

10. **"Chief of Staff"** shall mean the Chief of Staff of the Medical Staff.
11. **"Clinical Privileges"** or "Privileges" shall mean the permission granted by the Board to a Medical Staff

Member to render specific diagnostic, therapeutic, medical, dental, or surgical services.

12. **"Credentialing Data"** shall have the meaning set forth at 63 Okla. Stat. § 1-1709.1(A)(1).

13. **"Credentialing Process"** shall mean any process, program or proceeding utilized by the Hospital to assess, review, study or evaluate the Credentials of a health care professional.

14. **"Credentials Committee"** shall mean the Credentials Committee of the Medical Staff.

15. **"De Novo Hearing"** shall mean a new hearing of a matter conducted by the Appellate Revenue Body as if I t had not been heard before and as if no decision had been rendered previously, and of the nature set forth in Section 7.10 of the Fair Hearing Plan. The terms "De Novo Hearing" and "Hearing De Novo" shall have the same meaning whether in capitalized or lower case style in these Bylaws.

16. **"Dentist"** shall mean an individual who has been awarded the degree of Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.D.M.) and who is licensed to practice dentistry in the state of Oklahoma.

17. **"Designees"** shall have the meaning assigned to that term in Section 6.5-5.

18. **"Emergency"** shall have the meaning assigned to that term in Section 6.6.

19. **"Ex-officio"** shall mean service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

20. **"Fair Hearing Plan"** shall mean the procedures set forth in the Fair Hearing Plan of the Medical Staff as approved by the Board.

21. **"Focused Professional Practice Evaluation" (FPPE)** shall mean a process whereby the organization evaluates the privilege specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege at the organization. FPPE is for a time-limited period during which the organization evaluates and determines the practitioner's professional performance.

22. **"Good Standing"** shall mean a Medical Staff member has met attendance requirements during the previous Medical Staff year, if applicable, and is not under a suspension of his appointment or admitting privileges or have any restrictions imposed on the exercise of any of his clinical privileges.

23. **"Hearing Committee"** shall mean the committee appointed under the Fair Hearing Plan to hear a request for an evidentiary hearing properly filed and pursued by an applicant or Medical Staff member.

24. **"Hospital"** shall mean Duncan Regional Hospital and Jefferson County Hospital and includes all inpatient and outpatient locations and services. Except as otherwise specified in the Bylaws, Medical Staff Rules or Medical Staff policies, references to "Hospital" shall be deemed to include all of the Hospital inpatient and outpatient facilities that are serviced by the Medical Staff.

25. "**Hospital Bylaw**s" shall mean the Bylaws of the Hospital.

26. "**Hospital Representative**" shall mean and include any member of the Board or of any committee thereof, any member of the Credentials Committee, any member of the Investigative Committee, any member of any Hearing Committee, any member of any Appellate Review Body, any member of any ad hoc investigation committee, the President and his designees, any member of the Medical Executive Committee, the Chief of Staff and his designees, any other officer of the Medical Staff, any Chairman of any medical staff committee, and any other officer, employee or agent of the Hospital and any other medical staff member who has been delegated responsibility for or requested to assist the Hospital or the Governing Body in (i) documenting, investigating, evaluating or providing information regarding the credentials of any applicant or medical staff member, or (ii) acting upon or making recommendations with respect to any application or request for appointment or reappointment to the Medical Staff or particular clinical privileges, or (iii) acting upon or making recommendations with respect to a medical staff member's competence or professional conduct, or (iv) gathering, maintaining or reporting information bearing upon an applicant's or Medical Staff member's credentials, or (v) participating in any other peer review process.

27. "**Licensure Board**" shall mean the Oklahoma State Board of Medical Licensure and Supervision for medical doctors; the State Board of Osteopathic Examiners for doctors of osteopathy; the Board of Governors of Registered Dentists of Oklahoma for Dentists, and the Oklahoma State Board of Podiatric Medical Examiners for Podiatrists.

28. "**Medical Executive Committee" or "MEC**" shall mean the Medical Executive Committee of the Medical Staff.

29. "**Medical Staff or "Staff**" shall mean the formally organized self-governing body consisting of those physicians, dentists and podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

30. "**Medical Staff Member" or "Member**" shall mean any practitioner who has been duly appointed to the Medical Staff and who is privileged to attend patients in the Hospital.

31. "**Medical Staff Year**" shall mean the period from January 1 to December 31.

32. "**Medico-administrative Officer**" shall mean a practitioner, employed by or otherwise serving the Hospital on a full- or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities are defined as those involving professional capability as a practitioner, such as to require the exercise of clinical judgment with respect to patient care and include the supervision of professional activities of practitioners under his direction.

33. "**National Data Bank**" shall mean the National Practitioner Data Bank established pursuant to Section 421 of the Act for the reporting of medical malpractice payments on behalf of, sanctioning by Boards of

Medical Examiners against, and Professional Review Actions against Practitioners.

34. **"Oklahoma Act"** shall mean the Professional Review Body Protection From Liability statute codified at 76Okla. Stat. §§24-29, and rules and regulations promulgated thereunder, as amended from time to time, or any successor legislation conferring comparable privileges and immunities.

35. **"Ongoing Professional Practice Evaluation" or "OPPE"** shall mean a documented summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise, or revoke existing privilege(s) prior to or at the end of the two-year license and privilege renewal cycle."

36. **"Organized Health Care Arrangement" or "OHCA"** shall mean an organizational structure recognized in the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Standards, which consists of one or more legally separate covered entities that are integrated clinically or operationally and in which participants need to share protected health information about their patients to manage their delivery of health care services.

37. **"Peer Review Information"** shall have the meaning set forth at 63 Okla. Stat. § 1-1709.1(A)(5).

38. **"Peer Review Process"** shall mean any process, program or proceeding utilized by the Hospital to assess, review, study or evaluate the credentials, professional conduct or health care services of an applicant or Medical Staff member, including any activity of a professional review body which is based on competence or professional conduct of an individual practitioner (i) to determine whether an applicant or Medical Staff member may have clinical privileges at the Hospital or membership on the Medical Staff; (ii) to determine the scope or conditions of such privileges or membership; or (iii) to change or modify such privileges or membership.

39. **"Physician"** shall mean an individual who has been awarded the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) and who is licensed to practice medicine in the state of Oklahoma.

40. **"Podiatrist"** shall mean an individual who has been awarded the degree of Doctor of Podiatric Medicine (D.P.M.) and who is licensed to practice podiatry in the state of Oklahoma.

41. **"Practitioner"** shall mean, unless otherwise expressly limited, any appropriately licensed physician, dentist, oral surgeon, podiatrist, or allied health practitioner.

42. **"Prerogative"** shall mean a participatory right granted, by virtue of Medical Staff category or otherwise, to a medical staff member and exercisable subject to the conditions imposed in these Bylaws and in other Hospital and medical staff policies, subject to the ultimate authority of the Board.

43. **"President"** shall mean the individual appointed by the Board to serve as President, chief executive officer and administrator of the Hospital. Such individual shall have the authority and duties set forth in Section 4.5.3 of the Hospital Bylaws.

44. **"Professional Review Body"** shall mean as appropriate to the circumstances, the Board of Directors, the MEC, the Credentials Committee, the Investigative Committee, the JCH Medical Staff Committee, any investigation committee, any Hearing Committee, any Appellate Review Committee, the President of the Hospital, the Chief of Staff, and any other person, committee or entity having authority to make an adverse recommendation with respect to or to take or propose an action against any applicant or Medical Staff member when assisting the Board of Directors in a peer review process.

45. "**Rules and Regulations**" shall mean the rules and regulations adopted by the Medical Staff to establish a framework for self-governance of medical staff activity and accountability to the Board of Trustees.

46. **"Special Notice"** shall mean written notification sent by certified mail, return receipt requested, or by personal delivery with signed acknowledgment of receipt. Notice is deemed given when mailed postage prepaid addressed to the last known address of the addressee.

47. **"Third Party"** shall mean and include any individual including a medical staff member, organization, association, corporation, partnership, Medical Staff, health care entity or other person from whom information has been requested by any professional review body or to whom information has been provided by a professional review body.

48. **"Unified Medical Staff"** shall mean a multihospital system where one unified and integrated medical staff exists as described in the Medicare Conditions of Participation allowing separately certified hospitals to share a single medical staff.

ARTICLE I: NAME

The name of this component of the Hospital shall be the Medical Staff of DRH Health.

ARTICLE II: PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the Medical Staff are:

2.1-1 To be the formal component through which:

A. The benefits of membership on the Medical Staff may be obtained by individual medical staff members, and

B. The obligations of medical staff membership may be fulfilled.

2.1-2 To serve as the primary means for accountability to the Board for the appropriateness of the professional performance and ethical conduct of the Medical Staff and to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at a level of quality and efficiency achievable by the state of the healing arts and the resources locally available.

2.1-3 To provide a means through which the Medical Staff may formulate recommendations in the Hospital's policy-making and planning process and through which such policies and plans are communicated to and observed by all medical staff members.

2.1-4 To provide on behalf of the Hospital an appropriate educational setting and to maintain scientific and educational standards for undergraduate, graduate, and continuing medical education programs for students, residents, and the Medical Staff.

2.2 RESPONSIBILITIES OF THE MEDICAL STAFF

The responsibilities of the Medical Staff, to be fulfilled through the actions of its officers and committees, include, without limitation:

2.2-1 Accounting for the quality and appropriateness of patient care rendered by all medical staff members authorized to practice in the Hospital through the following measures:

A. A credentials program, including mechanisms for recommendations regarding appointment and reappointment, and the granting of clinical privileges to be exercised or of specified services to be performed, consistent with the verified credentials and current demonstrated performance of an applicant or medical staff member;

B. A structure that provides for the continuous monitoring of patient care practices and the enforcement of Medical Staff and Hospital policies;

C. Review and evaluation of the quality of patient care through valid and reliable patient care review and other performance improvement activities based on objective, clinically sound criteria;

D. A utilization management program designed to assure that medical and health care services at the Hospital are appropriately employed for meeting patients' medical, social, and emotional needs consistent with sound health care utilization practices;

E. A continuing education program, fashioned at least in part on the needs demonstrated through the utilization management and performance improvement programs.

2.2-2 Making proposed recommendations to the Board concerning actions with respect to appointments, reappointments, staff category, clinical privileges, and corrective action.

2.2-3 Reporting to the Board regarding the quality and efficiency of patient care rendered to patients of the Hospital through regular reports and recommendations concerning the implementation, operation, and results of the utilization management and performance improvement activities.

2.2-4 Initiating and pursuing corrective action with respect to medical staff members, when warranted.

2.2-5 Developing, administering, and seeking compliance with these Bylaws and other Hospital policies.

2.2-6 Participating in the Board's short- and long-range planning activity, to assist in identifying community health needs, to suggest to the Board appropriate institutional policies and programs to meet those needs and to recommend to the Board action with respect to acquisition of medical equipment.

2.2-7 Providing a means whereby issues concerning the Medical Staff and the discharge of Medical Staff responsibilities may be discussed with the Hospital administration and/or the Board.

2.2-8 Exercising the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities in a proper and timely manner.

2.2-9 Developing, administering, and recommending amendments to these Bylaws and the Rules and Regulations of the Medical Staff and its various components.

2.3 RESPONSIBILITIES OF THE GOVERNING BOARD

2.3-1 The Governing Board shall uphold the Medical Staff Bylaws, Rules and Regulations, and Policies that have been approved by the Governing Board.

ARTICLE III: MEDICALSTAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a privilege which shall be extended only to professionally competent physicians, dentists and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to, and membership on, the staff shall confer on a medical staff member only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws, and shall include staff category. No practitioner shall admit or provide services to patients in the Hospital unless he is a member of the staff or has been granted temporary privileges in accordance with the procedures set forth in Section 6.5 or is providing services to a patient under the circumstances provided in Section 6.6. A medical staff member is neither an employee nor an independent contractor of the Hospital, unless such a relationship is separately established between the Hospital and such medical staff member.

By applying for and/or accepting appointment to the Medical Staff, or by applying for, accepting and/or exercising clinical privileges within the Hospital, each applicant and each medical staff member agrees to abide by the terms and provisions of these Bylaws, the Fair Hearing Plan, the Rules and Regulations of the Medical Staff, policies and procedures, and any other policies and procedures of the Hospital, all as adopted and in effect from time to time unless medically indicated by the standard of care.

3.2 BASIC QUALIFICATIONS FOR MEMBERSHIP

Except as expressly modified in Section 4.5 for appointment to the Emergency Room Staff, every practitioner who seeks or enjoys medical staff membership must, at the time of appointment and unless specifically stated to the contrary thereafter, demonstrate to the satisfaction of the appropriate committees of the Medical Staff and of the Board the following qualifications and any additional qualifications and procedural requirements as are set forth in other sections of these Bylaws or related manuals.

3.2-1 LICENSURE

Each applicant must have a currently valid unrestricted license issued by the State of Oklahoma to practice medicine, surgery, dentistry, or podiatry. In addition, if the practitioner's clinical privileges are such that controlled substances will be prescribed, the practitioner must maintain a current controlled substances registration certificate as issued by the Drug Enforcement Administration and the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control.

3.2-2 BOARD CERTIFICATION

All initial physician applicants must be either ABMS or AOA board certified, board eligible or demonstrate that he has obtained the training requisite to board certification in the areas of core privileges requested. If the applicable board eligibility requirements include the successful completion of a residency program, this residency program must be completed or be within six months of completion through an approved postgraduate training program. If the residency is not completed on the scheduled date the staff membership will be terminated. In the event that the board eligibility requirements include a post-residency practice requirement, this requirement may be met at the Hospital provided that all other requirements for medical staff membership are met. All initial dentist and podiatrist applicants must have successfully completed an approved postgraduate training program.

Continued medical staff membership will require a physician who is board eligible to obtain board certification in the proposed area of practice within five (5) years of initially becoming board eligible. The Board of Directors of the Hospital shall have the power to waive the board certification requirement only under very extraordinary circumstances. Such circumstances will be a critical need for the talents of the applicant. The applicant should either (i) be licensed to practice medicine in the United States for at least three (3) years, or (ii) the applicant has achieved extraordinary recognition in the field of medicine as evidenced by nationally or internationally recognized awards, publications, or appointments to or promotion to a full-time faculty position at the professional level in a United States Accredited College of Medicine. The Credentials Committee will review the critical need and the qualifications of the individual and make a recommendation to the MEC which would then forward the recommendation to the Board of Directors who have the final authority and approval.

For purposes of this section and these Bylaws, an "approved" postgraduate training program for physicians is a residency program fully accredited throughout the time of the practitioner's training by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or an equivalent organization in a country eligible for licensure by endorsement of current license by the Licensure Board. An approved post-graduate training program for Podiatrists and Dentists is one fully accredited throughout the time of the practitioners training by the Commission on Dental Accreditation, by the Council on Podiatric Medical Education of the American Podiatric Medical Association, or by a successor agency to any of the foregoing or by an equivalent professionally recognized national accrediting body in the United States or in a country eligible for licensure by endorsement of current license by the Licensure Board.

The requirement outlined in these Bylaws for satisfactory completion of approved postgraduate training, and the board certification requirements outlined in these Bylaws, shall be waived for any practitioner who was a member of the Medical Staff for three (3) continuous years immediately prior to the effective date of this Bylaw provision.

3.2-3 PROFESSIONAL EDUCATION AND TRAINING

Each applicant must be a graduate of an approved medical, dental, or podiatric school or school of

osteopathy, or certified by the Educational Council for Foreign Medical Graduates, or have a Fifth Pathway certificate and have passed the Foreign Medical Graduate Examination in the Medical Sciences. For purposes of these Bylaws, an "approved" school is one fully accredited during the time of the practitioner's attendance by the Liaison Committee on Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation, by the Council on Podiatric Medical Education of the American Podiatric Medical Association, or by a successor agency to any of the foregoing or by an equivalent professionally recognized accrediting body, or by an equivalent organization in a country eligible for licensure by endorsement of current license by the Licensure Board.

3.2-4 PRACTICE EXPERIENCE

Each applicant must have actively practiced at least 18 months out of the previous 24 months in clinical practice or in an approved residency training program.

3.2-5 OFFICE AND RESIDENCE

Each applicant must have an office and residence in a location which, in the opinion of the Credentials Committee, allows the rendering of continuous, timely, necessary quality care to hospitalized patients of the practitioner.

3.2-6 PROFESSIONAL LIABILITY INSURANCE

Each applicant must satisfy the requirements of Section 13.3 pertaining to Professional Liability Insurance.

3.2-7 PERFORMANCE

Each applicant must be able to document his professional education, training, experience, and clinical results, demonstrating a continuing ability to provide patient care services at a generally recognized professional level of quality, current competency which is demonstrated by a lack of negative outcomes, and efficiency given the current state of the healing arts and consistent with available resources.

3.2-8 ATTITUDE

Each applicant must demonstrate a willingness and capability, based on current attitude and evidence of performance:

A. To work with, and relate to, other medical staff members, AHPs, members of other health disciplines, Hospital management and employees, the Board, visitors and the community in general, in a cooperative, professional manner sufficiently to convince the Hospital that all patients treated by them in the Hospital will receive quality care and that the Hospital and its medical staff will be able to operate in an orderly manner that is essential for maintaining a Hospital environment appropriate to quality and efficient patient care.

B. To participate equitably in the discharge of medical staff obligations appropriate to medical staff membership category.

C. To adhere to generally recognized standards of professional ethics to include the Principles of Medical Ethics as adopted by the American Medical Association or a

similar nationally adopted code of ethics for the specific profession of the practitioner, including without limitation, seeking consultation whenever necessary and obtaining patient consent, providing for continuous care of patients, prohibitions against fee-splitting or other inducements relating to patient referral, "ghost" surgical and medical services, and delegating the responsibility for diagnosis or care of patients to a practitioner not qualified to undertake that responsibility and who is not adequately supervised.

3.2-9 HEALTH STATUS

Each applicant must provide information concerning the applicant's physical and mental health, in the manner and to the extent permitted by applicable laws and regulations. Immunization history and current tuberculosis skin test is required. Distant site providers with telemedicine-only privileges are excluded from this requirement.

3.2-10 VERBAL AND WRITTEN COMMUNICATION SKILLS

In order to assure the health and safety of patients of the Hospital, each applicant must demonstrate the ability to read and understand the English language, to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

3.2-11 HOSPITAL AND COMMUNITY NEED, AND ABILITY TO ACCOMMODATE

In accordance with Hospital Bylaws and Section 3.8 hereafter, in acting on applications for medical staff membership and clinical privileges, and on applications for changes in clinical privileges or in medical staff membership status, consideration must be given to the Hospital's current and projected patient care needs and the Hospital's ability or willingness to provide the facilities, beds, and support services that will be required if the application is acted upon favorably.

In making these required need/ability determinations, consideration will be given to utilization patterns, present and projected patient mix, actual and planned allocations of physical, financial, and human resources to general and specialized clinical and support services, and the Hospital's and Medical Staff's general and specific goals and objectives reflected in the Hospital's short- and long-range plans.

3.2-12 EFFECT OF OTHER AFFILIATIONS

No practitioner is entitled to membership on the Medical Staff or to the exercise of particular clinical privileges solely because he is licensed to practice in this or in any other state, or because he is a member of any professional organization, or is certified by any clinical board, or because he is a member of the faculty of a medical school, or presently or formerly held medical staff membership or privileges at another health care facility or in another practice setting, nor is any practitioner automatically entitled to appointment, reappointment, or particular privileges merely because he had, or presently has, medical staff membership or those particular privileges at this Hospital, or that he meets any written minimum criteria which may be adopted by the Board from

time to time.

3.2-13 NON-DISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of age, gender, gender expression, race, creed, color, marital status, sexual orientation, national origin, or disability unrelated to the ability to fulfill patient care and required Medical Staff obligations or on the basis of any other criterion unrelated to: (a) the efficient delivery of quality patient care in the Hospital, or (b) professional qualifications, or (c) the Hospital's purpose, needs, and capabilities, or (d) community needs.

3.2-14 ADMINISTRATIVE AND MEDICO-ADMINISTRATIVE OFFICERS

A practitioner employed by the Hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Hospital and to the terms of their contract or other conditions of employment, and need not be a member of the Medical Staff. Conversely, a Medico-administrative Officer must be a member of the Medical Staff, achieving this status by the procedure provided in Article VI for both initial appointment and reappointment through the same procedures used for all other applicants and medical staff members. Their clinical privileges must be delineated in accordance with Article VII. The Medico-administrative officer's privileges shall not be contingent on their continued occupation of that position, unless otherwise provided in an employment agreement or other arrangement.

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each medical staff member, regardless of his assigned medical staff category, and each practitioner exercising temporary privileges under these Bylaws shall:

A. Provide patients with continuous care at the professional level of quality and efficiency generally recognized as appropriate at facilities comparable to the Hospital and strive to maintain the financial viability of the Hospital;

B. Abide by the Medical Staff Bylaws and by all other established standards, policies, and rules of the Hospital and Medical Staff;

1. A history and physical examination shall be completed by the physician or licensed practitioner credentialed and privileged to perform a history and physical examination and placed in the medical record within twenty-four (24) hours after admission or prior to inpatient or outpatient surgery or any procedure requiring anesthesia services. A history and physical examination completed within 30 days before admission or registration for an outpatient procedure may be used provided an interval note by the attending physician is made reflecting any changes in the patient’s condition. The interval note shall be documented prior to inpatient or outpatient surgery or procedure, or within twenty-four (24) hours of admission.
2. The prenatal record may be used as the history and physical by the attending physician for obstetrical patients admitted for delivery. An interval note shall be completed by the attending physician prior to delivery. A history and physical shall be documented for patients not receiving prenatal care by an active medical staff member.

3. The Emergency Department provider's record may be used as the history and physical for patients having procedures involving anesthesia, including moderate sedation, in the Emergency Department.
4. In emergency situations where the history and physical cannot be documented or updated prior to surgery or procedures requiring anesthesia, the physician must indicate in the medical record that the surgery or procedure was conducted on an emergency basis.

C. Discharge such Medical Staff, committee, and Hospital functions for which he is responsible by medical staff category assignment, appointment, election, or otherwise;

D. Prepare and complete in timely manner the medical and other required records for all patients he admits or in any way provide care in the Hospital;

E. Abide by generally recognized standards of professional ethics;

F. Promptly notify the President of the revocation, reduction or suspension of his professional license, or the imposition of terms of probation or limitation of practice, by any state, or of the loss of medical staff membership or privileges at any hospital or other health care institution, or the filing of charges by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Oklahoma, of the filing of a suit against the medical staff member or practitioner alleging professional liability, or if professional liability insurance is canceled or if there is a proposed failure to renew;

G. Provide services to medical assistance patients and other patients without personal physicians in accordance with the protocol adopted the Medical Staff delineating responsibilities for services to such patients;

H. Provide or arrange for the continuous care of patients admitted under his or her care.

3.4 DURATION OF APPOINTMENTS

3.4-1 INITIAL APPOINTMENTS

Except as otherwise provided in these Bylaws, initial appointments to the Medical Staff shall be for a period of up to two (2) years.

3.4-2 DURATION OF FPPE AND MODIFICATIONS

All initial appointments and all modifications of membership status or privileges pursuant to Section 6.5 shall be subject to a period of Focused Professional Practice Evaluation, with the condition that the initial appointment and grants of initial or increased clinical privileges do not expire until the proctoring requirements of Section 3.5 are satisfied.

3.4-3 REAPPOINTMENTS

Reappointments to the medical staff shall be for a period of not more two (2) years. The Board, after consultation with the Credentials Committee, may set a more frequent reappraisal period for the exercise of particular privileges by all medical staff physicians holding such privileges and/or for a medical staff member who has been the subject of disciplinary action. If reappointment of a medical staff member occurs during a voluntary leave of absence, the reinstatement requirements of 3.7-2 continue to apply following the end of the leave period.

3.4-4 EXCLUSIVE CONTRACTS

If the Hospital adopts an administrative policy involving an exclusive contract or other exclusive arrangement for a particular service or services, only those medical staff members covered under the exclusive contract/arrangement shall be privileged to provide services as of the effective date of the exclusive contract/arrangement. Medical staff members who are not a party to the exclusive/contract arrangement who were previously privileged to provide services shall not lose their clinical privileges as of the effective date of the exclusive contract/arrangement, but may no longer provide these services upon the effective date of the exclusive contract/arrangement whether or not such date coincides with the normal reappointment period. As set forth in Section 2.1-2(P) of the Fair Hearing Plan, no right to a hearing shall arise in connection with the inability of such medical staff members to continue to provide such services after the effective date of an exclusive contractor or other exclusive arrangement by the Hospital. As relates to this Section 3.4-3, exclusivity will not apply to HMO, PPO, IPA, or similar alternative health care delivery system contracts.

3.5 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

3.5-1 APPLICABILITY AND DURATION

All initially requested privileges shall be subject to a period of FPPE. The Credentials Committee will define circumstances that require the clinical performance of each practitioner to be monitored and evaluated after he or she is initially granted privileges at the hospital. Such monitoring may use prospective, concurrent, or retrospective proctoring, including but not limited to the following:

A. Concurrent proctoring – direct observation in real time;
B. Prospective proctoring – practitioners describe the treatment plan or procedure they intend to carry out. This may be conducted via phone;
C. Retrospective proctoring – cases are reviewed post-patient care for processes and outcomes;
D. Off-site proctoring may be accomplished by an individual(s) at another institution with the training and experience in a relevant specialty;
E. Review of operative and non-operative clinical procedures performed and their outcomes;
F. Blood utilization, medication management, morbidity and mortality data;
G. Requests for tests and procedures, use of consultants, medical record compliance, length of stays, utilization management;
H. Any other relevant criteria as deemed appropriate by the medical staff.

3.5-2 NO EFFECT ON MEMBERSHIP OR EXERCISE OF PRIVILEGES

During the FPPE period, a medical staff member must demonstrate all of the qualifications, may exercise all of the prerogatives, except as provided in Section 4.2-2 E, and must fulfill all of the obligations of their medical staff category. During the FPPE period, he may exercise all of the clinical privileges granted to them.

3.5-3 PROCEDURE FOR CONCLUDING OR EXTENDING THE FPPE

The Board, upon a recommendation of the Credentials Committee, may terminate the FPPE at any

time if the Credentials Committee determines that the practitioner has demonstrated the ability to exercise the clinical privileges initially granted to them. The Credentials Committee may make a recommendation to the Board that the FPPE period be extended. At any time during FPPE the Credentials Committee determines the practitioner has not adequately demonstrated their abilities, the Credentials Committee may make a recommendation to the Board that the Medical Staff membership or particular clinical privileges, as applicable, may be terminated. The medical staff member shall be entitled to the procedural rights provided in the Fair Hearing Plan, prior to final action by the Board.

3.5-4 FAILURE TO SUCCESSFULLY COMPLETE THE FPPE

A medical staff member who does not successfully complete FPPE within two (2) years does not qualify for advancement to regular Medical Staff status, may be scheduled for a personal interview with the Credentials Committee at the discretion of Credentials Committee or the affected medical staff member to discuss the status of the medical staff member's continued interest in maintaining an appointment to the Medical Staff of the Hospital. The Credentials Committee shall make the determination as to whether to make a recommendation concerning appointment or non-appointment to the regular Medical Staff, or nonrenewal of particular privileges, as applicable, if the medical staff member has not adequately demonstrated their abilities. A medical staff member whose appointment or privileges are recommended for nonrenewal by the Credentials Committee during FPPE shall be entitled to the procedural rights provided in Article VIII of the Fair Hearing Plan, prior to final action by the Board.

3.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT

3.6-1 QUALIFICATIONS AND SELECTION

A practitioner who is or who will be providing specified professional services pursuant to a contract with the Hospital must meet the same appointment qualifications, must be evaluated for appointment, reappointment, and clinical privileges in the same manner, and must fulfill all of the obligations of their category as any other applicant or medical staff member.

3.6-2 EFFECT OF APPOINTMENT TERMINATION OR CLINICAL PRIVILEGES RESTRICTION

Because practice at the Hospital is contingent upon continued medical staff appointment and is also constrained by the extent of clinical privileges enjoyed, a practitioner's right to use Hospital facilities is automatically terminated when medical staff appointment expires or is terminated. Similarly, the extent of a practitioner’s clinical privileges is automatically limited to the extent that pertinent clinical privileges are restricted or revoked.

The effect of an adverse change in clinical privileges on continuation of the contract is governed solely by the terms of the contract arrangement, or if the contract arrangement is silent on the matter, will be as determined by the Board after soliciting and considering the recommendations of relevant components and officials of the Medical Staff.

3.6-3 EFFECT OF CONTRACT EXPIRATION OR TERMINATION

The expiration or other termination of a contract will not affect the practitioner's appointment or clinical privileges, except that the practitioner may not thereafter exercise any clinical privileges in connection with the services which have expired or been terminated. As set forth in Section 2.1-2(P) of the Fair Hearing Plan, no right to a hearing shall arise in connection with the inability of such practitioner to continue to provide such services after the expiration or other termination of such contract.

3.6-4 TELEMEDICINE

Any physician who wishes to be granted telemedicine privileges must be credentialed through the mechanisms outlined in Article V of the Medical Staff Bylaws. Or if the distant site is a Medicare-participating entity that uses credentialing and privileging processes that meet or exceed Medicare standards, the practitioner may be privileged using credentialing information from the distant site.

3.7 LEAVE OF ABSENCE

3.7-1 LEAVE STATUS

A medical staff member may request a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC and the President, which states the period of time for the leave. A non-voluntary leave of absence may be requested only in the event of required military obligation. A leave of absence request may be granted by the MEC, subject to such conditions or limitations as the MEC shall determine to be appropriate. During the period of a leave the medical staff member's privileges and prerogatives shall not be exercised.

3.7-2 REINSTATEMENT AFTER LEAVE OF ABSENCE

At least sixty (60) days prior to the termination of the leave, or at any earlier time, the medical staff member may request reinstatement of their privileges and prerogatives by submitting a written notice to that effect to the President for transmittal to the Credentials Committee. The medical staff member shall submit a written summary of their relevant activities during the leave, if the Credentials Committee or the Board so requests. The Credentials Committee shall make a recommendation to the Board concerning the reinstatement of the medical staff member's privileges and prerogatives.

Failure to request reinstatement or to provide a requested summary of activities as above provided before termination of the leave will be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of medical staff membership, privileges, and prerogatives, without right of hearing or appellate review. A request for medical staff membership subsequently received from a medical staff member so terminated shall be submitted and processed in the manner specified in the Bylaws for applications for initial appointments.

3.8 LIMITING MEMBERSHIP IN SPECIALTIES OR SERVICES

The President shall have the authority, with the concurrence of the Chief of Staff and the MEC, to propose to the Board a limitation on the number of medical staff members within particular specialties or services of the Hospital by establishing numerical limitations on the admission of applicants for such specialty or service. The decision to limit the admission of new medical staff appointees in a particular specialty or service shall be based upon (i) written criteria developed by the President, the Chief of Staff and the MEC and distributed by the President, and (ii) a finding by the President that such action would be in the best interests of the total patient care function of the Medical Staff and the Hospital. The written criteria shall take into account those items specified in Section 3.2-11 hereof, including the utilization of the Hospital and each service, the average age of those medical staff members in each specialty who admit a majority of the patients in such specialty, the average waiting time for scheduling elective procedures by medical staff members for such specialty and any other factors deemed appropriate in evaluating the desirability or necessity of limiting the number of medical staff members in a particular specialty or service. Any decision to limit the number of medical staff members in a particular specialty or service must be approved by the Board at its next regularly scheduled meeting. The numerical limitation for any specialty or service (i) shall be reviewed on a periodic basis, but at least every two (2) years, by the President, and (ii) may be raised, lowered or rescinded by the President, with the concurrence by the Chief of Staff and the MEC, and with approval by the Board.

ARTICLE IV: MEDICAL STAFF CATEGORIES

4.1 CATEGORIES

The Medical Staff shall be divided into Active, Courtesy, Consulting, Emergency Room, Hospitalist and Honorary categories.

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS

The Active staff shall consist of medical staff members, each of whom:

A. Meets the basic qualifications set forth in Section 3.2;

B. Will provide for timely, continuous care to a practitioners patients requiring hospitalization and to assure availability within a reasonable time period when the patient's condition requires prompt attention.

C. Regularly admits patients to the Hospital or is otherwise regularly involved in the care of patients at the Hospital.

D. Each applicant with moderate sedation privileges must maintain certification in ACLS. Emergency Department physicians who maintain board certification in Emergency Medicine are exempt from this requirement.

4.2-2 PREROGATIVES

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

A. Admit patients to the Hospital as follows:

1. A physician member may admit patients according to their privileges.
2. A dentist member may admit patients in conformity with the requirements of Section 6.3.
3. A podiatrist may initiate the admission of patients in conformity with the requirements of Section 6.4.

B. Exercise such clinical privileges as are granted to them pursuant to Article VI. Participate in emergency room on-call or follow-up referral coverage as outlined in the Medical Staff Rules and Regulations.

D. Vote on all matters presented at general and special meetings of the Medical Staff and committees of which he is a member.

E. Hold office at any level in the Medical Staff component or be chairman of any committee, except during the FPPE period during which time the staff member may sit on committees but cannot hold office within the Medical Staff component.

4.2-3 DUTIES

Each member of the Active Medical Staff shall:

A. Meet the basic responsibilities set forth in Section 3.3;

B. Contribute to the organizational and administrative affairs of the Medical Staff, including

service in medical staff offices and on Hospital and medical staff committees, faithfully performing the duties of any office or position to which elected or appointed.

C. Retain responsibility within their area of professional competence for the care and supervision of each patient in the Hospital for whom he is providing services, or arrange a suitable alternative for such care and supervision;

D. Actively participate in patient care review and other performance improvement and utilization management activities required of the medical staff;

E. Discharge the recognized functions of medical staff membership by engaging in pertinent CME, attending charity patients as required, giving consultation to other medical staff members consistent with their delineated privileges, serving as a liaison physician for medical staff members during their FPPE period, and fulfilling such other medical staff functions as may reasonably be required of the medical staff members, including emergency service and on-call responsibility, if eligible, except as exempt by the Medical Staff.

F. Satisfy the requirements set forth in Article XI for attendance at meetings of the Medical Staff and committees of which he is a member;

G. Pay any applicable dues and assessments as determined by the Medical Staff and approved by the Board.

H. Fulfill the special appearance requirements in Section 11.8-3 of these Bylaws.

Refusal by an Active Staff Member to accept or properly fulfill the responsibilities set forth above, without justification, shall subject such Active Staff Member to reassignment to the Courtesy Staff or termination of medical staff membership and clinical privileges.

4.2-4 ACTIVE STAFF WITH REFER AND FOLLOW PRIVILEGES

4.2-5 QUALIFICATIONS

A. Meets the basic qualifications set forth in Section 3.2.

B. Refers patients for admission by fellow physicians or Hospitalists.

C. Exercise such clinical privileges as are granted to them pursuant to Article VI, but may never be solely responsible for managing a patient.

D. Utilizes the Hospital outpatient services as attending physician.

E. Request for transitioning to this category can be initiated by the Active Staff member or if deemed appropriate, by the Credentials Committee.

4.2-6 PREROGATIVES

The prerogatives of the medical staff member in this category shall be to:

A. Write admission orders only after contacting the physician to whom they are referring the patient for admission.

B. May refer patients to the outpatient facilities of the Hospital such as but not limited to ACU, sleep lab, radiology, laboratory, physical therapy, occupational therapy, speech therapy, cardiopulmonary, Homecare, and Hospice as deemed appropriate by the attending physician.

C. May provide professional interpretation of hospital setting diagnostic tests which do not require the physical presence of the physician interpreter at the time of the test, such as sleep studies or EKG's.
D. May provide care for patients in outpatient settings, such as The Wound Care Center and Sleep Lab per approved privileges.
E. Vote on all matters presented at general and special meetings of the Medical Staff and committees of which he is a member.
F. Hold office at any level in the Medical Staff component or be chairman of any committee, except during the FPPE period during which time the staff member may sit on committees but cannot hold office within the Medical Staff component.
G. If the physician chooses to return to full Active Staff category with admitting privileges, that could be granted if requested in writing within one year of being moved into the Refer and Follow category. This request to return to Active Staff with admitting privileges is made to the Credentials Committee who may recommend this change to MEC and the Board for approval. After one year as Active Staff with Refer and Follow privileges, full reapplication for admitting privileges would be required.

4.2-7 DUTIES

A. Actively participate in patient care review and other performance improvement and utilization management activities required of the Medical Staff;
B. Satisfy the requirements set forth in Article XI for attendance at meetings of the Medical Staff and committees of which he is a member;
C. Pay any applicable dues and assessments as determined by the Medical Staff and approved by the Board.
D. Fulfill the special appearance requirements in Section 11.8-3 of these Bylaws
E. Provide or arrange for the continuous care of their patients when utilizing the outpatient services of the hospital.
F. Provide a continuum of care for a patient whose care is initiated in the ACU and are sent to a tower room for completion of care.

4.3 COURTESY STAFF

4.3-1 QUALIFICATIONS

The Courtesy staff shall consist of medical staff members, each of whom:

A. Meet the basic qualifications set forth in Section 3.2.
B. Be in the same proximity to the Hospital as an active medical staff member, or demonstrate arrangements that are satisfactory to the Credentials Committee for alternative medical coverage for patients for whom they are responsible.
C. Admit, or refer to another medical staff member for admission, patients on only an occasional basis, as defined by the Credentials Committee.
D. Hold medical staff membership and demonstrate active participation in performance Improvement and utilization management activities at another hospital which is of a

substance and character similar to those at this Hospital, or agree to fulfill the obligations of active medical staff membership specified in these Bylaws concerning participation in performance improvement and utilization management activities at this Hospital and in the other provisions of these Bylaws as they pertain to participation in clinical programs and attendance at committee meetings, unless specifically waived by the Credentials Committee and concurred in by the MEC and Board.

E. At each reappointment time and at the conclusion of the FPPE period, provide evidence of clinical performance at their principal institution in such form as may be required by the Credentials Committee or other Medical Staff or Board authorities in order to allow an appropriate judgment to be made with respect to their ability to exercise the clinical privileges requested.

4.3-2 PREROGATIVES

The prerogatives of a Courtesy Medical Staff Member shall be to:

A. Admit patients on an occasional basis to the Hospital under the same conditions as specified in 4.2-2(A) for active medical staff members and provide medical consultation upon request of the attending practitioner;

B. Exercise such clinical privileges as are granted to them pursuant to Article VI;

C. Attend meetings of the Medical Staff and any Medical Staff or Hospital education programs;

D. Serve as a member of committees except for those specifically outlined in Article X. Courtesy Medical Staff Members shall not be eligible to vote at meetings or to hold elected office in the Medical Staff or any of its departments, and at times of full Hospital occupancy or of shortage of hospital beds or other facilities as determined by the President, the elective patient admissions of Courtesy Medical Staff Members shall be subordinate to those of Active Medical Staff Members. The President shall give verbal notice to Courtesy Medical Staff Members prior to implementing any prioritization of elective admissions as outlined in this section.

4.3-3 DUTIES

Each member of the Courtesy Medical Staff shall:

A. Discharge the basic responsibilities specified in Section 3.3 and 4.3-l(C);

B. Retain responsibility within their area of professional competence for the care and supervision of each patient in the Hospital for whom he is providing services, or arrange a suitable alternative for such care and supervision; and

C. Pay any applicable dues and assessments as determined by the Medical Staff and approved by the Board.

D. Fulfill the special appearance requirements in Section 11.8-3 of these Bylaws.

4.4 CONSULTING STAFF

4.4-1 QUALIFICATIONS

The Consulting staff shall consist of medical staff members, each of whom:

A. Possess specialized skills needed at the Hospital in a specific project or on an occasional basis in consultation when requested by a member of the Medical Staff;

B. Hold medical staff membership and demonstrate active participation in performance improvement and utilization management activities at another hospital which are of a substance and character similar to those at this hospital, or agree to fulfill the obligations of Active Medical Staff membership specified in these Bylaws concerning participation in performance improvement and utilization management activities at this Hospital and in the other provisions of these Bylaws as they pertain to participation in clinical programs and attendance at committee meetings.

4.4-2 PREROGATIVES

The prerogatives of a Consulting Medical Staff Member shall be to:

A. Exercise such clinical privileges as are granted to them pursuant to Article VI, but may never be solely responsible for managing a patient.

B. Utilizes the Hospital outpatient services as attending physician.

C. Attend meetings of the Medical Staff and any Medical Staff or Hospital education programs.

D. Serve as a member of committees except for those specifically outlined in Article X.

E. Consulting Medical Staff Members shall not be eligible to vote at meetings or to hold elected office in the Medical Staff.

4.4-3 DUTIES

Each member of the Consulting Medical Staff shall:

A. Discharge the basic responsibilities specified in Section 3.3 and 4.4-l (B).

B. Fulfill the special appearance requirements in Section 11.8-3 of these Bylaws.

4.5 EMERGENCY ROOM MEDICAL STAFF

4.5-1 QUALIFICATIONS

The Emergency Room staff shall consist of medical staff members, each of whom:

A. Meet the basic qualifications of Section 3.2, or

B. In lieu of meeting the requirements of Sections 3.2-2 through 3.2-5 be:

1. A physician with (a) a total of five (5) years' experience, with not less than 7,000 hours of emergency department work experience during that five (5) years; (b) the five (5) years to include an uninterrupted period of 24 months during which the physician averaged at least 100 hours of emergency department service per month; and (c) the physician obtains at least 50 hours of CME credits per year in courses related to emergency medicine or primary care, or;
2. A physician in the third year of an emergency medicine residency in an approved American postgraduate training program with at least one year of experience working independently in an emergency department outside of the residency program. These physicians will be required to work their first three (3) shifts with the emergency room medical director or assistant medical director. The medical director or assistant medical director will determine as to whether they are experienced enough to safely perform core emergency care on their own. Successful completion of the three required shifts will be documented and placed in the physician's file, or;
3. A physician that has completed a primary care or internal medicine residency in an approved American postgraduate training program and has either completed or is currently training in an emergency medicine fellowship. The physician must have at least one year experience working independently in an emergency department outside of the residency program. These physicians will be required to work their first three (3) shifts with the emergency room medical director or assistant medical director. The medical director or assistant medical director will determine as to whether they are experienced enough to safely perform core emergency care on their own. Successful completion of the three required shifts will be documented and placed in the physician's file.

A secondary emergency room physician must:

A. Have successfully completed an advanced cardiac life support program within the past two (2) years and all other training requirements outlined in the Medical Staff Rules and Regulations.
B. Meet the basic qualifications of Section 3.2, or
C. In lieu of meeting the requirements of Sections 3.2-2 through 3.2-5 be:
   1. A physician with (a) a total of five (5) years' experience (b) the Physician obtains at least 50 hours of CME credits per year in the courses related to emergency medicine or primary care, or;
   2. A physician in the final year of a primary care residency in an approved American postgraduate training program (as defined in Section 3.2-2). For this subsection, "primary care" means family medicine, internal medicine, emergency medicine, pediatrics, or general surgery, or;.
   3. A physician in the second year of an emergency medicine residency in an approved American postgraduate training program (as defined in Section 3.2-2)

may be allowed to work in lieu of a mid-level practitioner in the emergency department. These physicians would require direct oversight by the primary emergency department physician. The primary emergency department physician would be required to sign all charts for the 2nd year resident.

4.5-2 PREROGATIVES

The prerogatives of an Emergency Room Medical Staff Member are to:

A. Exercise such clinical privileges as are granted to them pursuant to Article VI.
B. Attend meetings of the Medical Staff and any Medical Staff or Hospital education programs;
C. Serve as a member of non-elective committees as appointed by the chief of the Medical Staff in Article X.
D. Emergency Room Medical Staff Members shall not be eligible to vote at meetings or to hold elected office in the Medical Staff.

4.5-3 DUTIES

Each member of the Emergency Room Medical Staff shall:

A. Discharge the responsibilities specified in the contractual agreements between the Hospital and the entity providing the services of the Emergency Room Medical Staff Physician.
B. Agree to fulfill the following obligations concerning participation in performance improvement and utilization management activities at this Hospital:
    1. Meet the basic responsibilities set forth in Section 3.3;
    2. Actively participate in patient care review and other performance improvement and utilization management activities required of the Medical Staff;
    3. Discharge the recognized functions of medical staff members by engaging in pertinent CME.
    4. Satisfy the requirements set forth in Article XI for attendance at meetings of the Medical Staff and committees of which he is a member;
    5. Pay any applicable dues and assessments as determined by the Medical Staff and approved by the Board.
    6. Fulfill the special appearance requirements in Section 11.8-3 of these Bylaws.
C. Agree to fulfill the other provisions of these Bylaws as they pertain to participation in clinical programs and attendance at committee meetings unless specifically waived by the Credentials Committee and concurred in by the MEC and Board.

4.6 HOSPITALIST PHYSICIANS

4.6-1 QUALIFICATIONS

A Hospitalist physician must meet the requirements for Hospitalist Staff membership as follows:

A. Meet the basic qualifications set forth in Section 3.2
B. Remain within the vicinity of the hospital as outlined in the Hospitalist contract
C. All physicians who work as a hospitalist must maintain current certification in ACLS.

4.6-2 PREROGATIVES

The prerogatives of the Hospitalist Staff Member shall be to:

A. Exercise such clinical privileges as are granted to them pursuant to Article VI.
B. Attend meetings of the Medical Staff and any Medical Staff or Hospital education programs;
C. Serve as a member of non-elective committees as appointed by the Chief of Medical Staff in Article X.
D. Hospitalist Staff Members who have completed 2 years of full time service may apply to the Credentials Committee for the privilege of voting.
E. Hospitalist staff members shall not be eligible to hold elected office of the Medical Staff.

4.6-3 DUTIES

Each Hospitalist Staff Member shall:

A. Discharge the responsibilities specified in the contractual agreements between the Hospital and the entity providing the services of the Hospitalist Physician.
B. Agree to fulfill the following obligations:
    1. Meet the basic responsibilities set forth in Section 3.3;
    2. Actively participate in patient care review and other performance improvement and utilization management activities required of the Medical Staff;
    3. Discharge the recognized functions of Medical Staff Members by engaging in pertinent CME.
    4. Satisfy the requirements set forth in Article XI for attendance at meetings of the Medical Staff and committees of which he is a member;
    5. Pay any applicable dues and assessments as determined by the Medical Staff and approved by the Board.
    6. Fulfill the special appearance requirements in Section 11.8-3 of these Bylaws.
C. Agree to fulfill the other provisions of these Bylaws as they pertain to participation in clinical programs and attendance at committee meetings unless specifically waived by the Credentials Committee and concurred in by the MEC and Board.

4.7 HONORARY STAFF

Membership through election or appointment on the Honorary Medical Staff is restricted to the following two (2) classes of practitioners:

A. Former medical staff members whom, upon retirement from practice, the Medical Staff wishes to honor in recognition of long standing service to the Hospital or other noteworthy contributions to its activities; and
B. Other practitioners of outstanding professional attainment not necessarily resident in the community. None of the specific qualifications, prerogatives, or obligations provided for other medical staff categories are applicable or available to members of the Honorary Medical Staff. Honorary Staff Members shall not be eligible to admit or attend patients, to vote on any matters, to hold office or serve on committees. Honorary Staff Members shall be permitted to attend meetings of the Medical Staff, but are not required to attend any such meetings.

4.8 QUALIFICATIONS GENERALLY

Every applicant and medical staff Member who seeks or enjoys medical staff membership must satisfy, at the time of appointment and unless specifically stated to the contrary continuously thereafter, the basic qualifications set forth in Section 3.2 as well as any additional qualifications that attach to the medical staff category to which he seeks appointment or of which he is a member.

4.9 LIMITATIONS OF PREROGATIVES

The prerogatives set forth under each Medical Staff category are general in nature and may be subject to limitation by special conditions attached to a Medical Staff Member's membership, by other sections of these Bylaws, and by other policies of the Hospital.

4.10 PARTICIPANTS IN PROFESSIONAL GRADUATE EDUCATION PROGRAMS

Participants in professional graduate education programs assigned by their school to members of the Medical Staff as preceptors, may participate directly in the management of patient care while under the supervision and direction of their preceptor (i) only to the extent permitted under Oklahoma law and (ii) only so long as the preceptor is a medical staff member who is a qualified licensed independent practitioner and has unsupervised and unrestricted clinical privileges at the Hospital.

A professional graduate education (PGE) program participant must submit to the Hospital (i) evidence of professional liability insurance coverage; (ii) a letter from the chairperson of their PGE program indicating that such participant is a member in good standing of the relevant program; (iii) a letter from the participant's medical staff preceptor containing a commitment to supervise such PGE program participant, and (iv) any additional items deemed necessary by the Hospital. PGE program participants shall only be assigned as permitted by the agreement between the Hospital and the applicable PGE programs. The Medical Staff Rules and Regulations shall contain more specific information regarding permissible patient care activities for different categories of PGE participants, limitations on chart entry and order writing, and other related matters.

ARTICLE V: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

5.1 GENERAL PROCEDURE

The Medical Staff, through its designated committees and officers in accordance with these Bylaws, shall investigate and consider each application for appointment or reappointment to the Medical Staff and each request for modification of medical staff membership status or privileges and shall adopt and transmit proposed recommendations thereon t the Board. Specific procedures for conducting this process are contained in these Bylaws.

5.2 APPLICANT'S BURDEN

The applicant shall have the burden of producing adequate information for a proper evaluation of their experience, professional ethics, background, training, demonstrated ability, and health status (in the manner and to the extent permitted by applicable laws and regulations), and of resolving any doubts about these or any of the other basic qualifications specified in Section 3.2 and any of the additional qualifications required of the medical staff category to which he requests appointment or reappointment, and of satisfying any reasonable requests for information or clarification made of him by appropriate authority of the Medical Staff or the Board.

In the case of a medical staff member granted initial privileges on the basis of board eligibility, as defined in Section 3.2-2, continued reappointment will be considered, for a period of five (5) years only from the date of initially meeting the board eligibility requirements of the specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association. If the physician has not become board certified in the areas of core privileges requested by a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association within five (5) years of becoming board eligible as defined in Section 3.2-2, the physician must demonstrate that he has obtained the training requisite to board certification or he shall voluntarily surrender all privileges at the Hospital. This requirement shall be waived for any physician who was a member of the Medical Staff for three (3) continuous years immediately prior to the effective date of this Bylaw provision.

5.3 APPLICATION FOR INITIAL APPOINTMENT

5.3-1 PRE-APPLICATION/APPLICATION FORM

Each request for application materials shall be submitted in writing on the form prescribed by the Board, and signed by the potential applicant. All individuals claiming to be practitioners who provide a written request for application materials shall be forwarded an application request form by the President in a timely fashion.

A. CONTENT

The application request form shall include such provisions as are necessary to secure

information which will document the potential applicant's ability to meet the general qualifications for membership as outlined in these Bylaws. Such information shall include without limitation the following:

1. Hospital Affiliations: A listing of all hospitals in which the potential applicant has had clinical privileges during the past five (5) years;
2. Board Certification: A copy of the potential medical staff member applicant's board certification, OR a letter from the specialty board indicating the practitioner's eligibility to take the board's examination OR evidence of training requisite to board certification.
3. Licensure: Current licensure and controlled substances information, as applicable;
4. Liability Insurance: Verification of required professional liability insurance c overage as required by Section 13.3.

B. VERIFICATION OF INFORMATION ON PRE-APPLICATION REQUEST FORM

The potential applicant shall deliver a completed application request form to the President, who shall, in timely fashion, seek to collect or verify the licensure and other qualification evidence submitted. The President shall promptly notify the potential applicant of any problem in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information.

C. SUBMISSION OF PRE-APPLICATION REQUEST FORM

The President, in consultation with the Credentials Committee, shall review the pre-application request form, supporting documentation, and such other information that may be relevant to determine whether the potential applicant meets the basic requirements for membership, and to determine if the Hospital has the ability to accommodate the practitioner’s specialty or sub-specialty. If the potential applicant is found to not meet the basic requirements for medical staff membership, or the Hospital is unable to accommodate the practitioner’s specialty or sub-specialty, the individual shall be so notified. Should the completed pre-application request form indicate that the requesting individual does not meet such minimum criteria, pursuant to Section 2.1-2(F) of the Fair Hearing Plan; no right to a hearing shall arise. If the President makes a favorable determination, an application form shall be provided to the potential applicant.

5.3-2 APPLICATION FORM

Each application for medical staff membership shall be in writing on the form prescribed by the Board, and signed by the applicant. All practitioners completing the pre-application request form and determined by the President, in consultation with Credentials Committee, to meet the basic qualifications for medical staff membership and it has been determined that the Hospital has the ability to accommodate the practitioner’s specialty/sub-specialty, shall be provided an application for medical staff membership by the President. A copy of the Medical Staff Bylaws and Rules and

Regulations shall be furnished, or shall be accessible, to each such person.

A. CONTENT

The application form shall include:

1. Acknowledgment and Agreement: A statement that the applicant has received (or has had access to) and read the Bylaws, Rules and Regulations of the Medical Staff and that they agree to be bound by the terms thereof if they are granted membership and/or clinical privileges, and to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not they are granted membership and/or clinical privileges.
2. Qualifications: Detailed information concerning the applicant's qualifications, including information in satisfaction of the basic qualifications and of any additional qualifications specified in these Bylaws for the particular staff category to which the applicant requests appointment.
3. Requests: Requests stating the staff category and clinical privileges for which the applicant wishes to be considered.
4. Professional Sanctions: Information as to whether any of the following have ever been, or whether any proceeding is pending or has been instituted which, if decided adversely to applicant, would result in the following being denied, revoked, suspended, reduced, restricted, not renewed, or voluntarily or involuntarily relinquished:
   a. staff membership status or clinical privileges at any other hospital or health care institution;
   b. membership/fellowship in local, state or national professional organizations;
   c. specialty board certification/eligibility;
   d. license to practice any profession in any jurisdiction; or
   e. drug enforcement agency or other controlled substances registration.

   If any of such actions ever occurred or are pending, the particulars thereof shall be included.
5. Criminal Sanctions: Information as to whether the applicant has ever been charged with, or convicted of, a felony, and the details about any such instances.
6. Professional Liability Insurance: A statement, including provision of a certificate of insurance, that the applicant carries professional liability insurance of a kind and in at least the minimum amount required by Section 13.3 and information on their or her malpractice claims history and experience during the past ten (10) years, including a consent to the release of information by their present and past malpractice insurance carrier(s).
7. Professional References: A request for a minimum of three professional references shall be obtained from practitioners in the same professional discipline as the applicant with personal knowledge of the applicant’s ability to practice. The purpose is to assure that peer recommendations are part of the

basis for the development of recommendations for individual clinical privileges.

8. Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity, and release provisions of Section 5.3-2(B) and Article XIII.
9. Administrative Remedies: A statement whereby the applicant agrees that, if an adverse ruling is made with respect to their membership, staff status, and/or clinical privileges, they will exhaust the administrative remedies of these Bylaws and Fair Hearing Plan before resorting to formal legal action.
10. Photo Identification: A photocopy of the applicant's current hospital identification card with photo, or a valid photo identification issued by a state or federal agency (i.e., driver's license or passport).

B. EFFECT OF APPLICATION

By applying for appointment or reappointment or for advancement in medical staff category, or for particular clinical privileges or changes in clinical privileges, the applicant or staff member:

1. Signifies their willingness to appear for interviews in regard to the application,
2. Authorizes Hospital representatives to consult with others who have been associated with them and/or who may have information, including otherwise privileged and confidential information, bearing on their competence and qualifications.
3. Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of their personal and professional qualifications and ability to carry out the clinical privileges requested, of their health status (in the manner and to the extent permitted by applicable laws and regulations), and professional ethical qualifications.
4. Signifies their willingness to provide an immunization history record and submit to a TB test as required by the Oklahoma State Health Department OAC 310:667-5-4. Distant site providers with telemedicine-only privileges are excluded from this requirement.
5. Releases from any liability all Hospital representatives for their acts performed in good faith in connection with evaluating the applicant and their credentials in accordance with Article XIII hereof.
6. Releases from all liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith concerning the applicant's ability, professional ethics, character, health status (in the manner and to the extent permitted by applicable laws and regulations), emotional stability, and other qualifications for medical staff appointment and clinical privileges in accordance with Article XII hereof.
7. Authorizes and consents to Hospital representatives providing Hospital affiliates, other hospitals, medical associations, licensing boards, and other

organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital may have concerning them, and

8. Releases Hospital representatives from liability for so doing, provided that such furnishing of information is done in good faith and in accordance with Article XII hereof.
9. Consents to National Practitioner Data Bank reporting as required and/or permitted by the Act.
10. Consents to a criminal background report.

C. MISTATEMENTS AND OMISSIONS

Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of misstatement or omission and permitted to provide a written response. The Chief of Staff and President will review the response and determine whether the application should be processed further.

If appointment has been granted prior to the discovery of a misstatement of omission, appointment and privileges may be deemed to be automatically relinquished.

No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal.

D. PROCESSING OF APPLICATIONS

Applications shall be considered in a timely and good faith manner by all individuals and groups required hereby to act thereon, and except for good cause, shall be processed within the time periods specified in this Section. That notwithstanding, the time periods specified herein are intended to assist those named in accomplishing their tasks and shall not be deemed to create any right for an applicant to have their application processed within such time periods. Notwithstanding the foregoing, no application for appointment shall be processed if it shows on its face that the applicant does not meet the minimum qualifications for appointment set forth.

1. Determination of Completeness/Verification of Information by the Medical Staff Coordinator. Upon receipt of a fully executed application from an applicant, the Medical Staff Coordinator shall, in timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Medical Staff Coordinator shall promptly notify the applicant of any problem in obtaining the information required and it shall then be the applicant's obligation to assure that the required information is transmitted to the Medical Staff Coordinator. In such regard, the applicant shall be informed that processing of the application will not begin until the application has been entirely completed.

For the purposes hereof, an application shall be deemed to be complete when all information requested in the application has been provided, letters of reference have been received from a minimum of three (3) individuals, and all information has been adequately verified. In the event such verification and collection process is not completed within sixty (60) days of receipt of the application, the Medical Staff Coordinator shall submit a status report to the Credentials Committee indicating the same at its next regular meeting. When collection and verification are completed, the Medical Staff Coordinator shall transmit the application and all supporting materials to the Credentials Committee for its review and consideration. If any questions arise on a completed application, the application becomes incomplete until the applicant provides the information requested by either the medical staff coordinator or Credential Committee. The requested information must be received within thirty (30) days or the application is considered withdrawn.

2. Credentials Committee Action. The Credentials Committee shall review the application, supporting documentation, availability of hospital resources and community need as determined in Section 3.8, and other information available, that may be relevant to consideration of the applicant's qualifications for the staff category and clinical privileges requested, at its first meeting subsequent to receipt of the application. The Credentials Committee may also conduct an interview of the applicant. The Credentials Committee shall take action as to an application, in accordance with Subsections (a)-(c) below, within ninety (90) days of receipt of the application from the Medical Staff Coordinator.

   a. Favorable Recommendation. If the recommendation of the Credentials Committee is favorable to the applicant, the Credentials Committee will review the application and proceed in accordance with applicable laws and regulations. After such review, the Credentials Committee shall promptly forward the applications, along with any additional reports or information, to the MEC for its review and comment, pursuant to Section 5.3-2(C)(3) below.

   b. Proposed Adverse Recommendation. If the proposed recommendation of the Credentials Committee is adverse to the applicant, the Credentials Committee shall promptly so advise the President and the President shall inform the applicant of the proposed adverse recommendation by special notice within five (5) days. In such event, the applicant shall be entitled to the procedural rights as provided in the Fair Hearing Plan, except as otherwise set forth in these Hospital Bylaws.

   c. Deferral. If the Credentials Committee elects to delay consideration of

an application based upon a limited number or no opening in the specialty, sub-specialty, or staff category requested, the Credentials Committee shall forward directly to the President for transmittal to the Board of Directors a proposed recommendation that the application be deferred.

(i) Reconsideration of Application. As openings in the specialty, sub-specialties or staff categories arise subsequent to deferral of an application, the Credentials Committee shall reconsider the current deferred applications and, if possible, make recommendations to the MEC for filling such positions with the most qualified applicants, in accordance with this Section 6.,3-2(C), with no priority being given based upon initial application date. That notwithstanding, within forty-five (45) days following deferral of an application, the Credentials Committee shall reconsider the same and either make a proposed recommendation in accordance with Sections 6.3-2 (C)(2)(a) or (b) or elect to allow the application to remain deferred.

(ii) Renewal of Application. If an applicant is not selected for medical staff appointment within the six (6) month period following the date of their application, the application will be considered to have been withdrawn unless it is adequately and properly renewed by the applicant in writing. In such event, the applicant shall provide any information necessary to update all elements of the original application. Any renewed application shall be deemed current for an additional six (6) month period, subject to continual renewal in accordance herewith.

3. Medical Executive Committee Action. Within thirty (30) days of the date that a copy of the Credentials Committee recommendation is received, the MEC shall submit a recommendation, along with its comments directly to the President for transmittal to the Board of Directors at its next regular meeting. The MEC shall submit a written recommendation as to the staff appointment and, if appointment is recommended, reference to clinical privileges to be granted and any special conditions to be attached to such appointment. The report of the MEC shall also include specific reasons and references if in disagreement with the Credentials Committee and shall be informational only, and shall not be binding on the Board. The MEC shall inform the Medical Staff of the MEC's recommendation regarding each application or reapplication.

4. Board Action. The Board shall take final action on the application at its next regular meeting following receipt of all recommendations, reports and additional information collected under this Section 5.3-2.

   a. On Favorable Credentials Committee Proposed Recommendation. The Board shall adopt or reject, in whole or in part, a favorable proposed recommendation of the Credentials Committee, or refer the recommendation back to the Credentials Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. When the Board's proposed decision is contrary to the recommendation of the Credentials Committee, conflict resolution mechanisms outlined in Sections 6.9-2 and 6.10 of the Fair Hearing Plan shall be invoked. Prior to the Board taking any final action that adversely affects the applicant, the President shall so inform the applicant of the proposed action within five (5) days, by special notice. In such event, the applicant shall be entitled to the procedural rights provided in the Fair Hearing Plan.

   b. Without Benefit of Credentials Committee Recommendations: If the Board does not receive a Credentials Committee recommendation within ninety (90) days of receipt by the Credentials Committee of the application from the Medical Staff Coordinator, the Board may take action on its own initiative if so requested in writing by the applicant. If such action is favorable, it shall become effective as the final decision of the Board. Prior to the Board taking any final action that adversely affects the applicant, the President shall so inform the applicant of the proposed action within five (5) days, by special notice. In such event, the applicant shall be entitled to the procedural rights as provided in the Fair Hearing Plan.

   c. After Procedural Rights: In the case of an adverse Credentials Committee recommendation pursuant to Section 5.3 2(C) (2) (b) or an adverse Board decision pursuant to Section 5.3-2 (C) (4) (a) or (b), the Board shall take final action in the matter only after the applicant has exhausted or has waived their procedural rights, as provided in the Fair Hearing Plan. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter back to the Credentials Committee for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing may be conducted to clarify issues

which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board shall make a final decision either to appoint the applicant to the medical staff or to reject them for medical staff membership.

5. Denial for Hospital's Inability to Accommodate. In accordance with Section 3.8 of the Hospital Bylaws, a recommendation by the Credentials Committee or a decision by the Board to deny staff membership, staff category assignment or particular clinical privileges either:

   a. On the basis of the Hospital's determination that it is not feasible, economically or otherwise, to provide adequate facilities for the applicant and their patients;

   b. On the basis of an insufficient current or projected patient load to support an additional staff member with the skills and training of the applicant;

   c. On the basis of inconsistency with the Hospital's written plan of development, including the mix of patient care services to be provided, as currently being implemented, or;

   d. On the basis of a numerical limitation on the admission of applicants to a particular specialty or service shall not be considered adverse in nature and shall not entitle the applicant to the procedural rights as provided in the Fair Hearing Plan. A written request by the applicant to the President, the application shall be kept in a pending status for the next six (6) months. If during this period the Board determines justification for expenditure, increased permissive usage of facilities or other economic factors render it feasible to accept staff application for which an applicant is eligible, the President shall promptly so inform the applicant by special notice. This notification is the only obligation as to applicants with pending application status. Within thirty (30) days of receipt of such special notice, the applicant shall provide, in writing on the prescribed form, any information necessary to update all elements of the original application. Thereafter, the procedure provided in Section 5.3-2(C) for initial appointments shall apply.

6. Conflict Resolution. Whenever the Board's proposed decision is contrary to the Credentials Committee's proposed recommendation, the Board shall submit the matter to the Joint Conference Committee for review and recommendation as provided in Sections 6.9-2 and 6.10 of the Fair Hearing Plan before making its final decision and giving notice of its final decision.

7. Notice of Final Decision.

   a. Manner of Notice. Notice of the Board's final decision shall be given, through the President, to the Chief of Medical Staff and to the applicant by means of special notice. A decision and notice to appoint shall include (i) the staff category to which the applicant is appointed (ii) the clinical privileges he or she may exercise, and (iii) any special conditions attached to the appointment.

   b. Adverse Final Decision. Should the final decision be adverse to the applicant's request, notification to the applicant shall state the adverse action taken and include a statement of the reasons for the adverse action which, in the case of a denial of an initial application for staff appointment shall be sufficient if it contains a statement of the areas in which applicant's qualifications were found deficient.

   c. Mandatory Waiting Period. Any applicant who receives special notice of adverse final decision on an initial appointment application may not submit another application for appointment to the staff for a period of twelve (12) months following the date such applicant received the a special notice of adverse final decision.

5.4 REAPPOINTMENT PROCESS

5.4-1 INFORMATION FORM FOR REAPPOINTMENT

The President shall, at least ninety (90) days prior to the expiration date of the present appointment of each staff member, provide such member with a reappointment form prescribed by the Board for use in considering reappointment. Each staff member who desires reappointment shall, at least forty-five (45) days prior to such expiration date, send their reappointment form to the President. Failure to so return the form at least 45 days prior to the expiration date shall constitute a voluntary resignation of staff membership effective at the expiration of the member's current term. The President may waive the 45 day requirement upon a showing of good cause by the staff member for the failure to return within the required time. A staff member whose membership is so terminated shall not be entitled to the procedural rights provided in the Fair Hearing Plan.

5.4-2 CONTENT OF REAPPOINTMENT FORM

The reappointment form shall request the following data necessary to update the Medical Staff file on the staff member:

A. Continuing compliance with the minimum objective criteria set forth in Section 3.2.
B. Clinical competence, ethical behavior and clinical judgment in the treatment of patients.
C. Satisfactory fulfillment of responsibilities assigned under any emergency patient care call schedule.

D. Continuing training, education, and experience that qualifies the staff member for the privileges sought on reappointment.
E. Physical and mental health in the manner and to the extent such information may be considered under applicable laws.
F. The name and address of any other health care organization or practice setting where the staff member provided clinical services during the preceding period.
G. Membership, awards, or other recognition conferred or granted by any professional health care societies, institutions, or organizations.
H. Sanctions of any kind imposed or pending by any other health care institution, professional health care organization, or licensing authority, or charges or conviction of any felony.
I. Voluntary or involuntary relinquishment of membership in any professional health care organization, specialty board certification or eligibility, license to practice any profession in any jurisdiction, drug enforcement agency or other controlled substances number, or voluntary or involuntary termination of staff membership or limitation, reduction, or loss of clinical privileges at another institution.
J. Malpractice insurance coverage (including cancellations, non-renewals and limits), claims, suits, and settlements.
K. Such other specifics about the staff member's professional ethics, qualifications and ability that may bear on their ability to provide good patient care in the Hospital.
L. Current information regarding licensure and drug enforcement agency or other controlled substances numbers.
M. Certification(s) within the previous two (2) years for applicable practitioners (ACLS, PALS, etc.).

5.4-3 REAPPOINTMENT PROCESS

Requests for reappointment to the Staff shall be processed in accordance with the following procedure:

A. Application. Upon receipt of a reappointment application form, the Medical Staff Coordinator shall verify the staff member's current professional liability insurance coverage, licensure and/or certification, and any other items as required for the membership category or privileges requested. The Medical Staff Coordinator shall obtain an updated National Provider Databank (NPDB) report.
B. Ongoing Professional Practice Evaluation (OPPE) and Review of Privileges. If a staff member in any category has not exercised some or all of their privileges in the last two years, these privileges will be reviewed at reappointment to determine if the practitioner is still competent to perform these privileges taking into consideration OPPE and comparable procedures performed by the medical staff member.
C. Processing of Request. A written request for reappointment, submitted in accordance with this Section 6.4-3, shall be processed pursuant to the procedures outlined in Articles III and V hereof; provided that, (i) in addition to the information required to be submitted by the Medical Staff Coordinator to the Credentials Committee, the Medical Staff Coordinator shall additionally provide information and documentation supporting and/or evidencing the medical staff member's

conformance with the criteria of Section 6.4-2 hereof, and (ii) recommendations of the Credentials Committee shall be for either (a) renewal of appointment, (b) renewal of appointment with modified staff category or clinical privileges, or (c) termination of the staff member.

5.5 REQUESTS FOR MODIFICATION OF APPOINTMENT

A staff member may, either in connection with reappointment or at any other time, request modification of their medical staff category or clinical privileges by submitting a written application to the President on the prescribed form. Such application shall be processed as to the requested modifications in the same manner as provided in Section 6.4 for reappointment.

5.6 BOARD APPLIED CRITERIA

In accordance with Hospital Bylaws, the Board shall apply, in making its decisions in respect to appointments, reappointments, clinical privileges, and modifications of appointment, the criteria stated in Section 3.2-11 of these Bylaws.

5.7 MANDATORY WAITING PERIOD:

Any applicant who receives a final adverse action on an initial appointment may not submit another application for appointment until a full twelve (12) months have passed from the final effective date of the adverse action.

ARTICLE VI: DETERMINATION OF CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

6.1-1 IN GENERAL

Every practitioner providing direct clinical services at the Hospital by virtue of medical staff membership, in a temporary privilege situation, except as provided in Section 6.7, may exercise only those clinical privileges or provide patient care services as are specifically granted by the Board pursuant to the provisions of these Bylaws and the Rules and Regulations. Regardless of the level of privileges granted, each practitioner must reasonably provide or arrange for appropriate and timely medical care for the practitioners patients in the Hospital and to obtain consultation when necessary for the safety of their patient or when required by the Rules and Regulations or other policies of the Medical Staff, any of its clinical units, or the Hospital. In addition, each patient's general medical condition shall be the responsibility of a qualified physician member of the Medical Staff.

6.1-2 EXPERIMENTAL, NEW, UNTRIED OR UNPROVEN PROCEDURES/TREATMENT MODALITIES/INSTRUMENTATION

Experimental drugs, procedures, therapies, or tests may be administered or performed only after approval of the protocols involved by the Hospital. Any experimental or other new, untried, or unproven procedure/treatment modality/instrumentation may be performed or used only after the regular credentialing process has been completed, and the privilege to perform or use said procedure/treatment modality/instrumentation has been granted to the individual practitioner. For the purposes of this paragraph, a new, untried, or unproven procedure/treatment modality/instrumentation is one that is not generally related to an established procedure/treatment modality/instrumentation in terms of involving the same or similar skills, the same or similar instrumentation and technique, the same or similar complications, the same or similar indications, or the same or similar expected physical outcome for the patient as the established procedure/treatment modality/instrumentation.

6.2 DELINEATION OF PRIVILEGES IN GENERAL

6.2-1 REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for the clinical privileges desired by the applicant. A request by a staff member pursuant to Section 5.5 for a modification of privileges must be supported by documentation of training and/or experience supportive of the request.

6.2-2 BASIS FOR PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the practitioner's current licensure, education, training, experience, peer recommendations, current health status (to the

extent such information may be considered under applicable laws and regulations), utilization practice patterns, and demonstrated current competence, judgment and ability to perform requested clinical privileges. Additional factors that will be considered in determining privileges are those specified in Section 3.2-12 of these Bylaws, patient care needs for the type of privileges being requested by the applicant, the geographic location of the practitioner, availability of qualified medical coverage in their absence, and an adequate type and level of professional liability insurance. The basis for privileges determinations to be made in connection with periodic reappointment or otherwise shall include peer recommendations, observed clinical performance, and the documented results of the performance improvement and utilization management program activities required by these and the Hospital Bylaws to be conducted at the Hospital and in the case of additional privileges requested, evidence of appropriate training and experience supportive of the request. Privileges determinations shall also be based on pertinent information concerning clinical performance obtained from other sources including, but not limited to, other health care facilities where a practitioner exercises clinical privileges. This information shall be added to and maintained in the file established for a staff member, and shall be considered peer review information.

6.2-3 PROCEDURE

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article V.

6.3 SPECIAL CONDITIONS FOR ORAL SURGERY AND DENTAL PRIVILEGES

Requests for clinical privileges from oral surgeons and dentists shall be processed in the manner specified in Section 6.2. Surgical procedures performed by oral surgeons and dentists shall be subject to review by the surgery committee. All oral surgery and dental patients shall receive the same basic history and physical as patients admitted to other surgical services which shall be performed by the attending physician, except this requirement for medical evaluation by the attending physician shall not apply to qualified oral surgeons who have been granted the clinical privileges to perform a history and physical examination related to dentistry. The oral surgeon or dentist is responsible for that part of the history and physical examination related to dentistry.

A history and physical examination shall be completed by the attending physician or licensed practitioner credentialed and privileged to perform a history and physical examination and placed in the medical record within twenty-four (24) hours after admission or prior to inpatient or outpatient surgery or any procedure requiring anesthesia services. A history and physical examination completed within 30 days before admission or registration for an outpatient procedure may be used provided an interval note by the attending physician is made reflecting any changes in the patient's condition. The interval note shall be documented prior to surgery or procedure, or within twenty-four (24) hours of admission.

The attending physician shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall advise on the risk and effect of the proposed surgical procedure on the total health status of the patient. When significant medical abnormality

is present, the final decision on whether to proceed with the surgery must be agreed upon by the oral surgeon or dentist and the attending physician. Except in the event of an emergency admission, the attending physician shall be identified prior to admission of the patient for surgery to be performed by an oral surgeon or dentist member of the Medical Staff.

6.4 SPECIAL CONDITIONS FOR PODIATRIC PRIVILEGES

Requests for clinical privileges from podiatrists shall be processed in the manner specified in Section 6.2. Surgical procedures performed by podiatrists shall be subject to review by the surgery committee. All podiatric patients shall receive the same basic history and physical as patients admitted to other surgical services which shall be performed by the attending podiatrist.

6.5 TEMPORARY PRIVILEGES

6.5-1 CIRCUMSTANCES

In the event of a critical institutional need and upon the written concurrence with the chairman of the Credentials Committee and Chief of Staff, or their respective designees, the President, or their respective designee, may grant temporary privileges in the circumstances outlined below. In the event such temporary privileges are granted they shall be subject to the review and concurrence of the Credentials Committee at its next regular meeting.

A. To fulfill an important patient care need when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved but only after there is verification of current licensure and current competence.

B. Pendency of Application. When an applicant for staff membership or privileges with a clean application is awaiting review and recommendation by the MEC and approval by the Governing Body, but only after; there is verification of current licensure, relevant training or experience, current competence, the ability to perform the privileges requested, the results of the National Practitioner Data Bank query have been obtained and evaluated, the applicant has a clean application, no current or previously successful challenges to licensure or registration, has not been subject to involuntary termination of staff membership at another organization and has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges, and a minimum of two (2) complete and positive oral or written professional references have been received.

Temporary privileges may be granted in this circumstance for an initial period of sixty (60) days, with a single subsequent renewal not to exceed an additional sixty (60) days. Any such renewal shall be made upon the written recommendation of the chairman of the Credentials Committee and the written concurrence of the President and the Chief of Staff and may be made only when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges. Under no circumstances may they be initially granted or renewed if the application is still pending because the applicant has not responded in a satisfactory

manner to a request for clarification of a matter or for additional information. In the event that a medical service to the Hospital and its patient population is curtailed or restricted by the sudden absence of an approved provider, the President and Chief of Staff, or their designees, may grant initial temporary privileges for a maximum of five (5) days pending completion of the application by the applicant.

C. Short Term Locum Tenens. To a practitioner who will be serving as a locum tenens for a staff member in their established practice but only after: receipt of a current curriculum vitae documenting the fact that the practitioner meets the board certification and professional education and training requirements of these Bylaws; receipt of a minimum of two (2) complete and positive written or oral professional references specific to the privileges being requested; receipt of a letter from the employing physician verifying the need for the services, the qualifications of the practitioner, and the anticipated length of service; verification of licensure and controlled substances registration; receipt of a list delineating the requested privileges; receipt of documentation that the practitioner is covered under the professional liability insurance policy of the employing physician in an amount meeting the current medical staff requirements; receipt of a signed waiver of liability statement from the practitioner and submission of a data query to the National Practitioner Data Bank. The President or their designee shall verify satisfactory performance and staff membership at the prior three (3) principal hospitals where the practitioner has exercised the particular privileges being requested during the previous five (5) years. Additional information may be obtained from any hospital in which the practitioner has held privileges at the discretion of the President, Chief of Staff, and Credentials Committee. A short term locum tenens is granted privileges for a period not to exceed 30 consecutive calendar days and may not be renewed. Any extension of short term locum tenens privileges should be conducted in accordance with the provisions for long term locum tenens privileges in Section 7.5-1-D of these Bylaws.

D. Long Term Locum Tenens. To a practitioner who will be serving as a locum tenens for a staff member in their established practice but only after: receipt of a complete application for appointment as a locum tenens, including a request for specific privileges; verification of the qualifications required by these Bylaws; receipt of a minimum of three (3) complete and positive written or oral professional references specific to the privileges being requested; receipt of a letter from the employing physician verifying the need for the services, the qualifications of the practitioner, and the anticipated length of service and submission of a data query to the National Practitioner Data Bank. The President or their designee shall verify satisfactory performance and staff membership at the prior three (3) principal hospitals where the practitioner has exercised the particular privileges being requested during the previous five (5) years. Additional information may be obtained from any hospital in which the practitioner has held privileges at the discretion of the President, Chief of Staff, and Credentials Committee. A long term locum tenens is granted for a two (2) year period (subject to an annual verification of licensure, malpractice insurance, state and federal narcotics certificates, if applicable, and CME attendance) and shall apply to a maximum of 60 cumulative days of service during each year. A long term locum tenens may be renewed biannually for a maximum of 60

additional cumulative calendar days annually or the practitioner may be required to seek permanent privileges in accordance with these Bylaws at the discretion of the Credentials Committee. Temporary privileges may be granted during the pendency of an application for long term locum tenens privileges in accordance with Section 7.5-1-A recognizing that the limitations on the maximum days of service provided under this section shall still apply.

6.5-2 CONDITIONS

Temporary privileges shall be granted only after verification of information outlined in Section 6.5-1 above and only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability, and judgment to exercise the privileges requested. Special requirements of consultation and reporting may be imposed by the Chief of Staff including but not limited to mandatory second opinions on all surgeries, ICU admissions, or consultation/transfer of high risk cases. Before temporary privileges are granted, the practitioner must acknowledge in writing that they have received and read the Medical Staff Bylaws, and Medical Staff Rules and Regulations, and that they agree to be bound by the terms thereof in all matters relating to their temporary privileges. Whether or not such written agreement is obtained, said Bylaws, rules, regulations, and policies control in all matters relating to the exercise of temporary privileges.

6.5-3 TERMINATION OF TEMPORARY PRIVILEGES

On the discovery of any information, or the occurrence of any event of a professionally questionable nature, pertinent to a practitioner's qualifications or ability to exercise any or all of the temporary privileges granted, the President in conjunction with the Chief of Staff, and in their absence their official designees, must terminate any or all of such practitioner's temporary privileges, provided that the conduct or activities of a practitioner pose a threat to the life, health or safety of any patient, employee or other person present at the Hospital and the failure to take prompt action may result in imminent danger to the life, health or safety of any such persons. Such termination may be effected by those entitled to impose summary suspensions under these Bylaws. In the event of any such termination, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. The terminated practitioner shall confer with the substitute practitioner to the extent necessary to safeguard the patient.

6.5-4 RIGHTS OF THE PRACTITIONER

A practitioner shall not be entitled to the procedural rights afforded by Article VIII and The Fair Hearing Plan because of their inability to obtain temporary privileges or because of any termination or suspension of temporary privileges.

6.5-5 DEFINITION OF "DESIGNEES"

For purposes of this Section 6.5, when the phrase "or their designees" or the phrase "or their respective designees" is used in referring to the President, the Chairman of the Credentials Committee and the Chief of Staff, the "designee" shall be:

A. For the President the officer of the Hospital designated in administrative or Board policy as being authorized to act on behalf of the President in the granting of temporary privileges;
B. For the Chairman of the Credentials Committee: the Vice Chairman of the Credentials Committee;
C. For the Chief of Staff: the Vice Chief of Staff. In the event of the Vice Chief of Staff's absence, the Secretary of Staff could act on their behalf;
D. In the event of the Secretary of Staff's absence, the Member at Large could act on their behalf;
E. In the event of the Member at Large's absence, the immediate Past Chief of Staff could act on their behalf.

6.6 EXPEDITED CREDENTIALING

Appointment, reappointment, or renewal or modification of clinical privileges may be expedited only upon approval by the subcommittee of the Board of Directors which has been delegated the authority to render a decision regarding initial appointment, reappointment, and renewal or modification of clinical privileges. The subcommittee must consist of at least two voting members of the governing body, one of which must be a physician Board member, and must be consistent with the governing body bylaws as they relate to forming a governing body committee.

Any individual being considered for medical staff membership or delineated clinical privileges is subject to the qualifications and obligations of membership as outlined in the these Bylaws. Following a positive recommendation from the Credentials Committee and the Medical Executive Committee on an application, the committee of the governing body reviews and evaluates the qualifications and competence of the practitioner applying for appointment, reappointment, or renewal or modification of clinical privileges and renders its decision. A positive decision by the committee results in the status or privileges requested. The committee shall meet as often as necessary as determined by its chairperson. The full governing body ratifies all positive committee decisions at its next regularly scheduled meeting. If the committee's decision is adverse to an applicant, the matter is referred back to the Medical Executive Committee for further evaluation.

Expedited credentialing is neither a right nor a privilege. Candidates who do not meet the criteria for expedited credentialing will be processed through the usual credentialing process.

In order to be eligible for expedited approval, the following criteria must be met:

A. The application is complete and accurate with all requested information returned. (A complete application is one in which not only is the application itself complete but all primary source verification and information required by these Bylaws is complete as well.)
B. There are no discrepancies in information received and no negative or questionable information is received.
C. Medical staff/work history is unremarkable (i.e., no frequent moves or unexplained or alarming gaps).

D. The applicant's request for clinical privileges is consistent with the medical staff's designation for applicant's specialty and their experience, training, and current competency; and all applicable privileging criteria are met.
E. The applicant possesses a current, valid state license, professional liability insurance in limits specified, and federal/state controlled substance certificates, if applicable.
F. The applicant has indicated that he or she can safely and competently exercise the clinical privileges requested, with or without a reasonable accommodation.
G. The applicant's history shows an ability to relate to others in a harmonious, collegial manner.
H. At the time of renewal of privileges, documentation of activity in the hospital and/or verification from outside healthcare entities/peers sufficiently verifies current competence. Peer recommendations must include current information regarding medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.
I. At the time of renewal of privileges, the results of peer review activities and the performance improvement functions of the medical staff reveal no areas of concern.

Each of the following criteria will be thoroughly evaluated on a case-by-case basis and may lead to ineligibility for expedited credentialing:

A. The applicant's staff appointment, staff status, and/or clinical privileges have never been involuntarily resigned, denied, revoked, suspended, restricted, reduced, surrendered, or not renewed at any other healthcare facility.
B. The applicant has never withdrawn application for appointment, reappointment, or clinical privileges or resigned from the medical staff before a decision was made by another healthcare facility's governing board or to avoid denial or termination of such.
C. No licenses; DEA or other controlled-substance authorizations; membership in local, state, or national professional societies; or board certification have ever been suspended, modified, terminated, or voluntarily or involuntarily surrendered.
D. The applicant has not been named as a defendant in a criminal action or been convicted of a crime.
E. There are no past or pending malpractice actions, including claims, lawsuits, arbitrations, settlements, awards or judgments, that show an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
F. There are no proposed or actual exclusions and/or any pending investigations of the applicant from any healthcare program funded in whole or in part by the federal government, including Medicare or Medicaid.

6.7 DISASTER/EMERGENCY PRIVILEGES

During a disaster(s), in which the emergency management plan has been activated and the hospital is unable to handle the immediate patient care needs, the President/Chief Executive Officer or Chief of Staff or their designee(s) have the option to grant emergency privileges. Reference the current Emergency Operations Plan (EOP).

ARTICLE VII: CORRECTIVE ACTION

7.1 ROUTINE CORRECTIVE ACTION

7.1-1 CRITERIA FOR INITIATION

Corrective action may be taken against any medical staff member whenever the personal and/or professional conduct of such medical staff member are reasonably believed to be (1) detrimental to patient safety or inconsistent with the efficient delivery of patient care at the generally recognized professional level of quality; (2) disruptive to Hospital operation; (3) in violation of these Bylaws, Medical Staff Rules and Regulations, or other Hospital policies; or (4) damaging to the reputation of the Medical Staff, Hospital, or medical profession (5) conduct demeaning, derogatory, or disrespectful toward hospital team members, medical staff members or others. Whenever it appears that corrective action may be necessary, it may be initiated by any officer of the Medical Staff, by the chairman of any standing committee of the Medical Staff, by the President, or by the Board or any officer of the Board. Initiation of corrective action pursuant to Section 7.1 does not preclude imposition of summary suspension as provided for in Section 7.2, nor does it require the prior imposition of such a suspension.

7.1-2 REQUESTS AND NOTICES

All requests for corrective action shall be in writing, submitted to the MEC, and supported by reference to detailed information concerning the specific conduct or activities which constitute the grounds for the request. The Chief of Staff shall promptly notify the President in writing of all requests for corrective action received by the MEC and shall continue to keep the President fully informed of all action taken in connection therewith. To the extent the request relates to a reasonable suspicion that a medical staff member is impaired, the procedure set forth in the Hospital policy regarding impaired physicians shall control.

7.1-3 APPOINTMENT OF INVESTIGATIVE COMMITTEE/PROFESSIONAL REVIEW BODY

Except as otherwise provided in Section 7.1-2, after consideration of the request, by the MEC with input from the President, the Chief of Staff shall forward the request to a professional review body to conduct an informal investigation. The Professional Review Body will consist of the Investigative Committee or another committee. An “ad hoc” committee will only be created if a clearly defined conflict is determined to be present with the Investigative Committee. This determination will be made by the Medical Executive Committee. If the medical staff member who is being investigated is a member of the Investigative Committee, the Chief of Staff will appoint a replacement. If the Chief of Staff is the member being investigated they will excuse themselves from the proceedings and the Vice Chief of Staff will assume all subsequent responsibilities of the Chief of Staff related to this investigation The Professional Review Body shall have no voting members who are in direct economic competition with the affected medical staff member. If the medical staff member advises the Chief of Staff that they believe a member of the Professional Review Body does not meet this criteria, the Chief of Staff shall determine the merit of such contention and if the contention is found to be correct, the Chief of Staff shall

appoint a substitute to serve on the Professional Review Body. Such an informal investigation shall be considered an administrative matter and not an adversarial proceeding. A medical staff member shall be entitled to have legal counsel present during any meetings or discussions between such Member and the members of the Professional Review Body. The medical staff member who is under informal investigation may be invited to appear before the Professional Review Body.

7.1 –4 TEMPORARY RESTRICTION OR SUSPENSION

The President, the Chief of Staff, the MEC, the Investigative Committee, any ad hoc investigation committee and the Board shall each have the authority to restrict or suspend the affected medical staff member's clinical privileges while an investigation is pending for a period of no longer than seven (7) days. Upon the expiration of such 7-day period, the restriction or suspension shall be lifted automatically, unless the decision is made to impose summary suspension in accordance with the provisions of Section 7.2.

7.1-5 PRELIMINARY REPORT OF AD HOC INVESTIGATION COMMITTEE

Upon conclusion of its investigation, the ad hoc investigation committee shall submit a preliminary report to the President the party requesting the investigation and the affected medical staff member. Such report shall contain a statement detailing the preliminary findings, conclusions and recommendations of the ad hoc investigation committee. The President, the party requesting the investigation, and the affected medical staff member shall each be given the opportunity to submit comments on the preliminary report of the ad hoc investigation committee within fifteen (15) days following receipt of the preliminary report.

7.1-6 REPORT OF AD HOC INVESTIGATION COMMITTEE

After reviewing the written comments, if any, submitted by the President, the party requesting the investigation and/or the affected medical staff member, the ad hoc investigation committee shall complete a report containing a statement detailing the findings and conclusions of the committee. The ad hoc investigation committee may in its report recommend any action specified in Section 2.1-2 of the Fair Hearing Plan, for which no hearing right is accorded. However, the ad hoc investigation committee may only propose to make a recommendation for any of the actions specified in Section 2.1-1 of the Fair Hearing Plan, for which a hearing right is afforded. Either a proposal for recommendation or a final recommendation shall include the basis for such recommendation of the committee.

7.1-7 PROCEDURE AFTER REPORT OF AD HOC INVESTIGATING COMMITTEE

The report of the ad hoc investigation committee shall be forwarded to the Board (i) at such time as a hearing, if requested, is completed and the Hearing Committee's report is forwarded to the Board, (ii) at such time as any hearing right is waived, or (iii) upon its issuance if no hearing right exists. If the ad hoc investigation committee has made a proposal to recommend an action for which a hearing right is required under Section 2.1-1 of the Fair Hearing Plan, then the affected medical staff member shall be entitled to the procedural rights set forth in the Fair Hearing Plan before final action is taken by the Board. If a hearing is requested and the Hearing Committee or, upon appeal, an Appellate Review Body recommends a decision in accordance with the proposed

recommendation of the investigating committee, then the proposed recommendation shall be deemed to have been made, and the Board shall make the final decision in accordance with the provisions of the Fair Hearing Plan. If the right to hearing is waived, then the Board shall be notified that the proposed recommendation of the ad hoc investigation committee is a final recommendation of such Committee, and the Board shall take final action after reviewing the report of the Committee. If the ad hoc investigation committee does not propose to recommend any action as to which a hearing right is required under the Fair Hearing Plan, then the Committee's report and its recommendation shall be forwarded to the Board for final action.

7.2 SUMMARY SUSPENSION

7.2-1 CRITERIA AND INITIATION

Whenever there are reasonable grounds to believe that the conduct or activities of a medical staff member pose a threat to the life, health or safety of any patient, employee or other person present at the Hospital and that the failure to take prompt action may result in imminent danger to the life, health or safety of any such person, the Chief of Staff, the President (or in their absence their respective designees), the MEC or the Board shall each have the authority to suspend summarily the appointment of such medical staff member and/or all or any portion of their clinical privileges. Such summary suspension shall become effective immediately upon imposition, and the President shall promptly give special notice of the suspension to the medical staff member and report the suspension to the MEC and chairman of the Board. The suspended medical staff member's patients then in the Hospital whose treatment by such staff member is terminated by the summary suspension shall be assigned to another medical staff member by the Chief of Staff. The wishes of the patient shall be considered where feasible in choosing a substitute medical staff member.

7.2-2 PROCEDURAL RIGHTS

If a summary suspension is imposed pursuant to Section 7.2-1, the medical staff member shall be entitled to the procedural rights as provided in the Fair Hearing Plan.

7.2-3 MEC ACTION

If requested in writing by the suspended medical staff member, as soon as reasonably possible after such summary suspension and in all cases within seven (7) days, a meeting of the MEC shall be held to consider such summary suspension. The suspended medical staff member may, at their request, appear before this meeting of the MEC. After review, the MEC may propose a recommendation to the Board for modification, continuation or termination of the suspension. Should the MEC propose a recommendation to the Board for termination of the summary suspension, the Board shall meet in emergency session within three (3) days to take final action on the proposed recommendation to terminate the summary suspension. Should the Board approve the proposed recommendation to terminate the summary suspension, the affected medical staff member shall be given written notice that the summary suspension has been terminated and the right to a hearing is no longer applicable. A proposed recommendation by the MEC to continue the suspension, modify the suspension or take other adverse action shall entitle the medical staff member to the procedural rights set forth in Section 7.2-2. The terms of the summary suspension

as originally imposed shall remain in effect pending a final decision by the Board.

7.3 AUTOMATIC TERMINATION

Whenever any of the actions listed below occur, a medical staff member shall be automatically terminated from their appointment to the Medical Staff, and all of their clinical privileges shall terminate. If any medical staff member is subject to automatic termination for any reason, he shall not be entitled to a hearing or appellate review.

7.3-1 LICENSE

Automatic termination shall occur whenever a medical staff member's license, certificate or other legal credential authorizing them to practice in this state is revoked, restricted, suspended or placed on probation; provided however, that the placing of a medical staff member on probation by the Licensure Board and the imposition of only the standard conditions uniformly applied to all practitioners then being placed on probation by the Licensure Board shall not be the basis for automatic termination without the imposition of restrictions or conditions which in some way restrict the medical staff member's license or ability to practice or treat patients. However, the imposition of probation shall give rise to an investigation by an ad hoc investigation committee pursuant to Section 7.1-4.

7.3-2 CONTROLLED SUBSTANCES NUMBER

Automatic termination may occur whenever a medical staff member's Drug Enforcement Agency (DEA) or other controlled substances permit, license or right to prescribe is revoked or suspended in any manner. The imposition of any form of restriction of a medical staff member's DEA or other controlled substances permit shall give rise to an investigation by an ad hoc investigation committee pursuant to Section 7.1-4.

7.3-3 CONVICTION OF A FELONY

Automatic termination shall occur whenever a medical staff member is convicted of, or pleads no contest to, a felony or any crime involving the use and/or distribution of controlled substances.

7.3-4 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

Automatic termination shall occur when a medical staff member fails to satisfy the requirements of Section 11.8-3.

7.3-5 MEDICAL RECORDS

A medical staff member's clinical privileges (except with respect to their patients already in the Hospital),theirs rights to admit patients and to consult with respect to patients, and their voting and office-holding prerogatives shall, after written warning of delinquency, may be automatically terminated.

7.3-6 CERTIFICATIONS

If a medical staff member’s clinical privileges require current certification in Neonatal

Resuscitation (NRP), Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), or Advanced Trauma Life Support (ATLS) ("Certification"), such Certification shall be maintained and not allowed to expire or lapse. In the event a medical staff member's Certification has expired or lapsed, the staff member will be provided with a notice of delinquency giving them ninety calendar (90) days to obtain the appropriate recertification. If the medical staff member does not obtain recertification within the timeframe listed in the notice of delinquency, such member's clinical privileges that are relative to the certification will be automatically suspended. This administrative restriction of privileges is not reportable to the National Practitioner Databank. Clinical privileges may be reinstated by the Chief of Staff upon successful recertification

7.3-7 MALPRACTICE INSURANCE

Automatic termination shall occur for failure to maintain the amount of professional liability insurance required under Section 13.3.7.3-8 NOTICE AND REVIEW BY PRESIDENT:
If an automatic termination shall occur by reason of the occurrence of any of the foregoing events, the President shall promptly give notice of the automatic termination to the affected medical staff member, and the specific grounds for such termination. Within ten (10) days of receipt of notice of the automatic termination, the affected medical staff member shall have the right to present written evidence to the President which negates the grounds for the automatic termination. If the President determines, with the concurrence of the Chief of Staff, that the written evidence negates the grounds for the automatic termination, the President shall so notify the affected medical staff member, and the automatic termination reflected in the original notice shall be considered void from the beginning.

7.3-9 REAPPOINTMENT UPON CURING OF EVENT

If any medical staff member is automatically terminated for any reason they may reapply for initial appointment to the Medical Staff in accordance with these Bylaws upon curing the event or failure resulting in such automatic termination. However, upon reapplication, such terminated medical staff member shall have the burden of demonstrating that they meet the standards for appointment to the staff.

7.4 AUTOMATIC TERMINATION OF FPPE

Automatic termination shall be imposed at any time during the FPPE period when the Credentials Committee recommends to the Board, and the Board makes a determination pursuant to Section 3.5-4 that the medical staff member has not adequately demonstrated their abilities for medical staff membership and/or clinical privileges. The medical staff member shall be entitled to the procedural rights provided in the Fair Hearing Plan prior to any such final action by the Board.

7.5 CONTINUITY OF PATIENT CARE

Upon the imposition of summary suspension or the occurrence of an automatic termination, the Chief of Staff shall provide for alternative coverage for the patients of the suspended or terminated staff member's patients in the Hospital whose treatment by such staff member is terminated by such suspension or termination. The wishes of the patient shall be considered, where feasible, in choosing a substitute staff

member. The suspended staff member shall confer with the substitute staff member to the extent necessary to safeguard the patient.

ARTICLE VIII: INTERVIEWS, HEARINGS AND APPELLATE REVIEW

8.1 INTERVIEWS

When a Professional Review Body receives, or is considering initiating, an adverse recommendation concerning an applicant, medical staff member, the applicant or medical staff member may be afforded an interview with the Professional Review Body. The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The applicant, medical staff member shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of the interview shall be made.

8.2 HEARINGS AND APPELLATE REVIEW

When any applicant, medical staff member is given special notice of a proposed adverse recommendation or action of any Professional Review Body, they shall be entitled to the procedural rights set forth in the Fair Hearing Plan (attached as Addendum A).

8.3 REMOVAL FROM OFFICE OF MEDICO-ADMINISTRATIVE OFFICER

A. Unless otherwise provided in a medico-administrative officer's employment agreement or other arrangement, removal from a medico-administrative office shall have no effect on the medical staff membership status or clinical privileges of the removed officer.

B. A removed officer shall be entitled to the following procedural rights:

1. To the procedural rights provided by their employment agreement or other arrangement; or,
2. If there is no employment agreement or other arrangement or if the same is silent on the issue of procedural rights, to the procedural rights provided in Section 2.1 in the Fair Hearing Plan.

8.4 CHANGE IN MEMBERSHIP STATUS OR CLINICAL PRIVILEGES OF A MEDICO-ADMINISTRATIVE OFFICER

Unless a medico-administrative officer's employment agreement or other arrangement specifies otherwise, alteration in the officer's medical staff membership status and/or clinical privileges must be initiated and processed in accordance with Article VIII hereof.

ARTICLE IX: OFFICERS OF THE STAFF

9.1 OFFICERS OF THE STAFF

9.1-1 IDENTIFICATION

The officers of the Medical Staff shall be:

A. Chief of Staff
B. Vice-Chief of Staff
C. Secretary
D. One at-large member elected by the Medical Staff
E Immediate Past Chief of Staff
F JCH Medical Director

9.1-2 QUALIFICATIONS:

Officers must be members of the active Medical Staff at the time of nomination and election and must remain members in good standing during their terms of office and must faithfully discharge the duties of the office held. Failure to maintain good standing active status shall immediately create a vacancy in the office involved. No individual may hold two medical staff offices concurrently.

No medical staff member actively practicing in the Hospital is ineligible to be a medical staff officer solely because of their professional discipline or specialty.

9.2 NOMINATIONS

A minimum of sixty (60) days prior to the annual meeting of the Medical Staff, the MEC shall by majority consent appoint a search committee consisting of three (3) members of the Active Medical Staff in good standing. The search committee members shall be composed of a representative of each of the following three groups: the MEC, primary care (family medicine, internal medicine, pediatrics), and specialty practitioners. The search committee shall canvas the eligible members of the Active Medical Staff concerning their willingness to serve in an official capacity on the MEC. A concerted effort shall be made by the search committee to identify two or more candidates for each MEC position. The report of the search committee shall be presented at a regular monthly meeting of the Medical Staff not less than one month prior to the annual meeting. In addition to the report of the search committee, nominations shall be accepted from the floor at the annual meeting. Only members of the Active Medical Staff in good standing may submit names for nominations.

9.3 ELECTION

Officers and committee members for whom election is required shall be elected at the annual meeting of the Medical Staff. Voting shall be by ballot. A nominee shall be elected upon receiving a majority of the 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 candidates receiving the highest number of votes. The word "majority" in this section shall be construed to mean more than 50% of the votes cast in the balloting.

Upon approval of the Chief of Staff, a vote by mail-in/electronic voting may occur after a regular or special meeting where a quorum did not occur at the meeting or at the decision of the Chief of Staff. Mail-in/electronic voting shall occur in the form and format as designated by the Chief of Staff (fax, electronically, email, and/or survey). A ballot for the vote shall be distributed to all voting members of the Medical Staff not less than five days before the voting period. The voting period shall not be less than five nor more than seven days, and the voting period should be clearly stated on the ballot.

9.4 TERM OF ELECTED OFFICE

Each officer shall serve a one (1) year term, commencing on the first day of the Medical Staff Year following their election. Each officer shall serve until the end of their term and until a successor is elected, unless they sooner resigns or is removed from office.

9.5 RESIGNATION

Any officer may resign at any time by giving written notice to the MEC. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified in it.

9.6 REMOVAL OF OFFICERS

Removal of a medical staff officer may be effected by a two-thirds (2/3) vote of the medical staff members present at a meeting at which a quorum is present who are eligible and qualified to vote for medical staff officers, by secret ballot. Such vote be taken at a special meeting called for that purpose. Permissible basis of removal of a medical staff officer include, without limitation:

A. Failure to perform the duties of the position held in a timely and appropriate manner.
B. Failure to continuously satisfy the qualifications for the position.
C. Having a summary suspension or automatic termination imposed by operation Section 7.2 or 7.3 of these Bylaws or a corrective action matter pursuant to Section 7.1-1 of these Bylaws resulting in a final decision adverse to the medical staff officer.
D. Conduct or statements damaging to the best interests of the Medical Staff, Hospital, or medical profession or to their goals, programs, or public image.

Action directed towards removing an officer from office may be initiated by submission to the MEC of a petition seeking removal of an officer signed by not less than one-third (1/3) of the members of the Active Medical Staff with voting rights.

9.7 VACANCIES IN STAFF OFFICES

Vacancies in offices, other than that of Chief of Staff, shall be filled by the Medical Staff at their next regular meeting or special called meeting. If there is a vacancy in the office of Chief of Staff, the vice Chief of Staff shall become Chief of Staff and serve out the remaining term.

9.8 ELIGIBILITY FOR RE-ELECTION

A medical staff member who has served as an officer is eligible for re-election to that office; however, no individual shall serve more than two (2) consecutive full terms in the same office.

9.9 DUTIES OF ELECTED OFFICERS

9.9-1 CHIEF OF STAFF

The Chief of Staff shall serve as the chief medical officer and the principal elected official of the Medical Staff. The Chief of Staff is permitted to vote in elections but shall vote on routine matters only in the event of a tie. As the chief medical officer, he/she shall:

A. Aid in coordinating the activities and concerns of the Hospital administration and of the nursing and other patient care services with those of the Medical Staff;
B. Assist the President in organizing and coordinating the medical staffs' performance and utilization management program activities and advise the Board on these matters;
C. Appoint representatives to the Medical Staff and Hospital committees, unless otherwise expressly provided by these Bylaws or Hospital Bylaws, policies, or procedures;
D. Communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board and the President and participate in any Hospital deliberation affecting the discharge of medical staff responsibilities;
E. Be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a medical staff member;
F. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
G. Serve as chairman of the MEC and as an ex-officio member of all other medical staff committees.
H. Represent the Medical Staff, as an ex-officio member, at all meetings of the Board.
I. Serve as the spokesman of the Medical Staff in its external professional and public relations.
J. Be responsible for the educational activities of the Medical Staff.
K. In the event of a tie vote in a matter before the MEC, the Chief of Staff may cast an additional vote to break the tie.

9.9-2 VICE-CHIEF OF STAFF

The Vice-Chief of Staff shall be a member of the MEC. In the temporary or permanent absence of the Chief of Staff, he/she shall assume all of the duties and have the authority of the Chief of Staff. They shall perform such additional duties as may be assigned to them by the Chief of Staff, the MEC, or the Board.

9.9-3 SECRETARY

The secretary shall be a member of the MEC. Their duties shall be to:

A. Give proper notice of all Medical Staff meetings on order of the appropriate authority;
B. Prepare accurate and complete minutes for meetings (the secretary may designate a recording secretary for all committee and Medical Staff meetings);

C. Attend to all routine and special correspondence. Special correspondence involving or pertaining to the activities of the Hospital shall be referred to the Board through the President with the recommendations of the Medical Staff concerning the same.
D. Where there are funds to be accounted for, he/she shall also act as treasurer.
E. Perform such other duties as ordinarily pertain to their office.
F. In the temporary or permanent absence of the Chief of Staff and vice Chief of Staff, he/she shall assume all duties and responsibilities and have the authority of the Chief of Staff.

9.9-4 EXECUTIVE MEDICAL COMMITTEE MEMBER AT LARGE

The Executive Medical Committee Member at large shall be a member of the MEC and shall perform such additional duties as may be assigned to them by the Chief of Staff, MEC, or the Board. In the temporary or permanent absence of the Chief of Staff, vice Chief of Staff, and the Secretary, he/she shall assume all duties and responsibilities and have the authority of the Chief of Staff.

9.9-5 IMMEDIATE PAST CHIEF OF STAFF

The Immediate Past Chief of Staff shall be a member of the MEC and shall perform such additional duties as may be assigned them by the Chief of Staff, MEC or the Board. In the temporary or permanent absence of the Chief of Staff, Vice Chief of Staff, Secretary, and the Committee Member at Large, he/she shall assume all duties and responsibilities and have the authority of the Chief of Staff.

9.9-6 MEDICAL DIRECTOR OF JCH

The Medical Director of Jefferson County Hospital serves as the leader of the medical staff and AHP's who hold privileges at JCH. The Medical Director must practice significantly at Jefferson County Hospital. This person is responsible for the medical direction for JCH's health care activities and consultation for, and medical supervision of, the staff practicing at JCH. The Medical Director of JCH serves on the Medical Staff Credentials Committee. The Medical Director of JCH serves as a member of the MEC and reports the functions and activities of the JCH Medical Staff and AHP's to the MEC and Governing Board. The Vice Medical Director of JCH may assume these duties in the absence of the Medical Director.

ARTICLE X: FUNCTIONS AND COMMITTEES

10.1 FUNCTIONS OF THE STAFF

Provision shall be made in these Bylaws or by resolution of the MEC, either through assignment to medical staff committees, to the Medical Staff as a whole, to medical staff officers or officials, or to inter-disciplinary Hospital committees, for the effective discharge of the Medical Staff functions specified in this Section 10.1 and described in Section 10.2, of all other medical staff functions required by these Bylaws, and of such other medical staff functions as the MEC, the Medical Staff, or the Board shall reasonably require, including provisions to:

A. Govern, direct, and coordinate the Medical Staff and its various functions.
B. Plan, conduct, coordinate, and evaluate the Medical Staff components of the Hospital's quality improvement program.
C. Conduct, coordinate, and evaluate the effectiveness of monitoring activities, including tissue, blood usage, mortality, morbidity, and antibiotic and other drug use reviewed; analysis of autopsy reports; analysis of unexpected clinical occurrences; fulfillment of consultation requirements; and compliance with the Bylaws, Rules and Regulations, policies, and procedures of the Medical Staff and Hospital.
D. Conduct, coordinate, and evaluate the effectiveness of, or oversee the conduct of, utilization management activities.
E. Conduct, coordinate, and evaluate the effectiveness of special studies of the inputs, processes, and outcomes of care.
F. Monitor and evaluate care provided in, and develop clinical policy for:
    1. Special care units, and
    2. Patient care support services such as respiratory therapy, physical therapy, pathology, radiology, and anesthesiology.
G. Conduct, coordinate, and implement procedures for credentials investigations and recommendations regarding medical staff membership, grants of clinical privileges, corrective action and specified services for AHP's.
H. Provide and evaluate appropriate continuing education opportunities responsive to quality improvement program findings and to new developments applicable to clinical practice in the Hospital.
I. Plan, conduct, coordinate, and evaluate training of students.
J. Supervise the Hospital's professional library services.
K. Develop and review policies and practices on, and maintain surveillance over, the completeness, timeliness, and clinical pertinence of patient medical and related records.
L. Develop and maintain surveillance over drug utilization policies and practices.
M. Investigate and control Hospital-acquired infections and monitor the Hospital's infection control program.
N. Participate in planning for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community.
O. Direct medical staff organizational activities, including Medical Staff Bylaws review and revision, medical staff officer and committee nominations, liaison with the Board and Hospital

administration, and review and maintenance of Hospital accreditation.

P. Coordinate the care provided by Medical Staff Members and AHPs with the care provided by the nursing and support services and with the activities of other Hospital patient care and administrative services.

Q. To review the requirements of outside regulatory authorities and implement strategies to meet these requirements as appropriate.

10.2 DESCRIPTION OF FUNCTIONS

10.2-1 PERFORMANCE IMPROVEMENT AND MONITORING FUNCTIONS

The duties involved in conducting, coordinating, and reviewing performance improvement and monitoring programs are to:

A. Adopt, subject to the approval of the Medical Staff and the Board, an overall quality improvement plan as well as specific programs and procedures for reviewing and evaluating the quality and appropriateness of patient care within the Hospital and the clinical performance of all individuals with delineated clinical privileges, including at least mechanisms for:

1. Assigning responsibility for monitoring and evaluation activities, delineation of scope of care provided by the Hospital and identification of the most important aspects of care provided by the Hospital.
2. Identification of indicators and appropriate clinical criteria for monitoring important aspects of care.
3. Monitoring the important aspects of care by collecting and organizing data for each indicator and evaluating care to identify problems or ways to improve care.
4. Recommending to appropriate body's action to correct identified problems.
5. Monitoring activities designed to assure that the desired result has been achieved and sustained.
6. Reporting of the results of performance improvement activities to the Medical Staff, the President, and the Board.

B. Review, on a regular basis, and act upon, as necessary, factors affecting the quality and efficiency of patient care provided in the Hospital.

C. Conduct or supervise, and receive at least quarterly reports on the conduct of mortality reviews.

D. Conduct on a monthly basis surgical case review to assure that surgery performed is justified and of high quality. With regards to such review:

1. All cases should be reviewed regardless of whether tissue is removed, although an adequate sample of cases may be reviewed for procedures or practitioners consistently shown to be of high quality;
2. All tissues with major discrepancy between preoperative and postoperative diagnosis should be evaluated;
3. Predetermined criteria should be utilized to identify cases requiring further evaluation;
4. Written reports of all conclusions, recommendations, and actions should be maintained.

E. Conduct blood utilization studies at least quarterly, including:
   1. The evaluation of the appropriateness of all cases in which patients were administered transfusions, including the use of whole blood and blood components, although an adequate sample of cases may be reviewed when study consistently supports the justification and appropriateness of blood use;
   2. Review of each actual or suspected transfusion reaction;
   3. Review of the amount of blood requested, the amount used, and the amount of wastage;
   4. Review of the adequacy of transfusion services to meet patient need;
   5. Development or approval of policies and procedures relating to distribution, handling, use, and administration blood and blood components;
   6. Maintenance of written reports of all conclusions, recommendations, and actions.

F. Review on a continuous basis and coordinate compliance with consultation requirements and other established policies and protocols relating to clinical practice in the Hospital.

G. Coordinate the findings and results of:
   1. Committee and Medical Staff performance improvement and monitoring procedures;
   2. Hospital utilization management activities;
   3. Reviews of medical record completeness, timeliness, and clinical pertinence;
   4. Other medical staff activities designed to monitor patient care practices.

H. Submit reports to the MEC and Board on the overall quality and efficiency of medical care provided in the Hospital and on utilization management and on other quality review, evaluation, and monitoring activities.

10.2-2 UTILIZATION MANAGEMENT

The duties involved in conducting or overseeing the utilization management function are to:

A. Develop a utilization management plan that is appropriate to the Hospital and that meets the requirements of law. Such a plan must include provision for at least:
   1. Review of the appropriateness of medical necessity of admissions, continued Hospital stays and supportive services;
   2. Discharge planning; and
   3. Data collection and reporting.

B. Monitor the utilization plan.

C. Conduct such studies, take such actions, submit such reports, and make such recommendations as are required by the utilization management plan.

D. Submit reports as necessary to the coordinating authority required in Section 10.2-1(E), the President and the Board, including at least a summary of the findings of, and specific recommendations resulting from, the utilization management program.

10.2-3 CREDENTIALS FUNCTION

The duties involved in conducting, coordinating, and reviewing credentials and making proposed recommendations are to be conducted by the Credentials Committee and include:

A. Review and evaluate the qualifications of each applicant for initial appointment,

reappointment, or modification of appointment and for clinical privileges.

B. Review and evaluate the qualifications of each AHP applying clinical privileges.

C. Submit reports, in accordance with Articles V and VI, on the qualifications of each applicant for medical staff membership or clinical privileges, and each AHP for clinical privileges. Such reports shall include proposed recommendations with respect to appointment, medical staff category, clinical privileges, and special conditions attached thereto.

D. Investigate, review, and report on matters, including the clinical or ethical conduct of any medical staff member or AHP, assigned or referred by those responsible for the functions described in Sections 7.1-1, 10.2-1, 10.2-2, and 10.2-3.

E. Submit reports as appropriate to the MEC on the status of pending applications, including the specific reasons for any inordinate delay in processing an application or request.

F. Conflict of Interest: Whenever an applicant's or medical staff member's practice is in direct economic competition with the practice of a physician member of the Credentials Committee, the committee member shall abstain from voting during proceedings involving the applicant or medical staff member. Such abstention shall be recorded in the minutes of the meeting.

G. Meetings: The Credentials Committee shall meet as necessary and report its proposed recommendations to the Medical Executive Committee.

10.2-4 CONTINUING EDUCATION FUNCTION

The duties involved in organizing continuing education programs and supervising the Hospital's professional library services are to:

A. Develop and plan, or participate in, programs of continuing education that are relevant to the type of patient care delivered in the Hospital, designed to keep the Medical Staff informed of significant new developments and new skills in medicine, and responsive to performance improvement activity findings.

B. Evaluate, through the performance improvement function, the effectiveness of the educational programs developed and implemented.

C. Analyze, on a continuing basis, the Hospital's and the Medical Staff's needs for professional library services.

D. Act upon continuing education recommendations from the MEC, the Medical Staff, or committees responsible for patient care review, evaluation and monitoring functions.

E. Maintain a record of education activities and submit periodic reports to the MEC concerning these activities, specifically including their relationship to the findings of the performance improvement function.

10.2-5 MEDICAL RECORDS FUNCTION

The duties involved in reviewing the completeness, timeliness, and clinical pertinence of patient medical records are to:

A. Review and evaluate medical records to determine that they:
   1. Properly describe the condition and progress of the patient, the patient's diagnosis, the patient's condition at discharge, the therapy and tests provided, the results, thereof, and the identification of responsibility for all actions taken;
   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. Review Medical Staff and Hospital policies, Rules and Regulations relating to medical records, including medical records completion, forms, formats, filing, indexing, use of electronic data processing and storage systems for medical record purposes, storage, destruction and availability of records, and recommend methods of enforcement thereof and changes therein.

C. Act upon recommendations from the MEC and other organizational components responsible for performance improvement functions.

D. Provide liaison with Hospital administration, nursing service, and the medical records professionals in the employ of the Hospital on matters relating to medical records practices.

E. Review summary information regarding timely completion of medical records.

F. Maintain a record of all actions taken and submit periodic reports and recommendations to the MEC concerning medical records practices in the Hospital.

10.2-6 PHARMACY AND THERAPEUTICS FUNCTION

The duties involved in developing and maintaining surveillance over drug utilization policies and practices are to:

A. Assist in the formulation of broad professional policies, with the assistance of pharmacy, nursing, and administration, regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs and diagnostic testing materials in the Hospital.

B. Review and evaluate the prophylactic, therapeutic, and empiric use of drugs on an ongoing basis through a planned, systematic, criteria based process to assure appropriate, safe, effective use of drugs including:
   1. Routine collection and assessment of information to identify opportunities to improve use or drugs and resolve problems in use;
   2. Ongoing monitoring and evaluation of drugs with known risks of significant drug interactions or reactions, drugs used to treat patients at high risk of adverse reactions, drugs designated through performance improvement functions for monitoring and evaluation, and drugs in high use;
   3. Development of criteria based on current knowledge, clinical experience, and relevant literature;
   4. Use of results in reappointment and privileges delineation processes;

C. Advise the Medical Staff and the Hospital's pharmaceutical department on matters pertaining to the choice of available drugs, and review all untoward drug reactions.
D. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
E. Develop and review periodically a formulary or drug list for use in the Hospital.
F. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.
G. Establish standards concerning the use and control of investigational drugs and of r research in the use of recognized drugs.
H. Perform such other duties as assigned by the MEC.
I. Maintain written reports of all conclusions, recommendations, and actions relating to the pharmacy and therapeutics function and submit periodic reports and recommendations to the MEC concerning drug utilization policies and practices in the Hospital.

10.2-7 INFECTION CONTROL FUNCTION

The duties involved in preventing, investigating, and controlling Hospital-acquired infections are to:

A. Maintain surveillance over the Hospital infection control program.
B. Develop a system for reporting, identifying, and analyzing the incidence and cause of all infections.
C. Develop and implement a preventive and corrective program, approved by the Medical Staff, designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation, and sanitation techniques.
D. Develop, evaluate, and revise preventive, surveillance, and control policies and procedures relating to all phases of the Hospital's activities, including:
    1. Operating rooms, delivery rooms, special care units;
    2. Central service, housekeeping, and laundry;
    3. Sterilization and disinfection procedures by heat, chemicals, or otherwise;
    4. Isolation techniques;
    5. Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;
    6. Testing of Hospital personnel for carrier status;
    7. Disposal of infectious materials;
    8. Food sanitation and waste management;
    9. and other situations as requested.
E. Coordinate action on findings from the medical staff's review of the clinical use of antibiotics.
F. Act upon recommendations related to infection control received from the Chief of Staff, the MEC, and other Medical Staff and Hospital committees.
G. Maintain a record of all activities relating to infection control and submit periodic reports thereon to the MEC and to the President.

10.2-8 RISK MANAGEMENT

The duties involved in developing and maintaining surveillance over risk management practices

related to the clinical aspects of patient care and safety designed to identify, evaluate, and reduce the risk of patient injury associated with care are to:

A. Identify general areas of potential risk in the clinical aspects of patient care and safety.
B. Develop criteria and evaluate cases with potential risk in the clinical aspects of patient care and safety.
C. Correct problems in the clinical aspects of patient care and safety identified through risk management activities.
D. Design programs to reduce risk in clinical aspects of patient care and safety.
E. Maintain written reports of all conclusions, recommendations, and actions.

10.2-9 DISASTER PLANNING FUNCTION

The duties involved in planning to provide appropriate response to, and the protection and care of Hospital patients and others at the time of, internal and external disasters are to:

A. Develop and periodically review, in cooperation with the Hospital administration, a written plan designed to safeguard patients at the time of an internal disaster and require that all key personnel rehearse fire and other types of disaster drills.
B. Develop and periodically review, in cooperation with the Hospital administration, a written plan for the care, reception, and evacuation of mass casualties, and assure that such plan is coordinated with the inpatient and outpatient services of the Hospital, that it adequately relates to other available resources in the community and coordinates the Hospital's role with other agencies in the event of disasters in the Hospital and nearby communities, and that the plan is rehearsed by all personnel involved.

10.2-10 MEDICAL INFORMATICS OVERSIGHT FUNCTION

The duties involved in maintaining coherent and consistent clinician oversight and direction to the continuous revision, improvement, data governance and evaluation of the Electronic Health Record (EHR) and the other clinical information systems that comprise the EHR at Duncan Regional Hospital are to:

A. Assure there is consistent and coherent clinician direction for modifications and enhancements to the EHR that support all providers across the settings of care, including, but not limited to:
    1. Make decisions about use and configuration of the clinical information systems that comprise the EHR at Duncan Regional Hospital.
    2. All items presented will be evaluated with the appropriate representatives impacted by the item submitted
    3. All decisions or recommendations will be submitted to a majority vote
    4. When there is a lack of consensus or recommendations / decisions that are deemed to require further inquiry, the chair will discuss with the group the appropriate group or committee that must weigh in before a decision can be made.
    5. Decisions that significantly influence clinical practice will require the approval of Medical Staff.
    6. Recommend changes to Health System policies will be routed to Administration for approval.
B. Provide input, recommendations and guidance to the governance of workflows, data

capture, and data organization within the EHR.

C. Provide input and recommendations to the organization about strategic directions for the ongoing management and development of the EHR.

D. Evaluate, prioritize and approve the development and implementation of incremental modifications and enhancements in the functionality and operation of the EHR.

E. Make recommendations to the organization about opportunities and practices that would support the capture, documentation, display, analysis and reporting of clinical information.

F. Make recommendation to the organization about the education and training of providers around the use of the EHR.

G. Submit reports to the Medical Executive Committee (MEC) including updates on initiatives and significant decisions.

10.2-11 BYLAWS REVIEW AND REVISION FUNCTION

The duties involved in maintaining the appropriate Bylaws, Rules and Regulations, and other organizational documents pertaining to the Medical Staff are to:

A. Conduct a review of the Bylaws, Rules and Regulations, procedures, and forms promulgated in connection therewith as needed, but no less often than every three (3) years.

B. Submit recommendations to the MEC, Medical Staff, and to the Board for changes in these documents.

C. Receive and consider matters specified in subparagraph (A) as may be referred by the Board, the MEC, the Chief of Staff, the President, and committees of the Medical Staff.

10.3 DESIGNATION AND SUBSTITUTION

There shall be a MEC and such other standing and special committees of the Medical Staff responsible to the Medical Staff as may from time to time be necessary and desirable to perform the Medical Staff functions listed in Section 10.1 and elsewhere in these Bylaws. The MEC may establish a medical staff committee to perform one or more of the required medical staff functions. Those functions requiring participation of, rather than direct oversight by, the Medical Staff may be discharged by medical staff representation on such Hospital committees as are established to perform such functions.

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

A. A committee, but no appropriate committee shall exist, the MEC shall perform such function or receive such report or recommendation or shall assign the functions of such committee to a new or existing committee of the Medical Staff or to the Medical Staff as a whole.

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

10.4 MEC

10.4-1 COMPOSITION

The MEC shall be composed of the following individuals:

A. The current Chief of Staff
B. The Vice-Chief of Staff
C. The Secretary of the Staff
D. One at-large member elected by the Medical Staff
E. The most recent past Chief of Staff not otherwise serving as a member of the committee
F. The Medical Director of JCH

The Chief of Staff is chairman and presiding officer. The Vice-Chief of Staff is vice-chairman to act in the chairman's absence. The Presidents,'or their designee, may attend each meeting of the MEC without vote. A majority of executive committee members are fully licensed physician members of the Medical Staff actively practicing in the Hospital.

10.4-2 DUTIES

The MEC functions include, but are not limited to:

A. Make proposed recommendations to the Board and Medical Staff on at least the following:
    1. The structure of the Medical Staff
    2. The mechanism used to review credentials and delineate individual clinical privileges
    3. The organization of the performance improvement activities of the Medical Staff including the mechanism used to conduct, evaluate, and revise these activities
    4. Mechanisms to terminate medical staff membership
    5. Fair hearing procedures
B. Receive, coordinate, and act upon reports and proposed recommendations from the committees and officers of the Medical Staff and the discharge of their delegated administrative responsibilities and recommend to the Board specific programs and systems to implement these functions.
C. Coordinate the activities of, and policies adopted by, the Medical Staff and committees.
D. Receive and review reports relative to matters relating to appointments, reappointments, Medical Staff category, clinical privileges, and corrective action and submit reports to the Board as provided for in these Bylaws.
E. Account to the Board and to the Medical Staff for the overall quality and efficiency of patient care in the Hospital.
F. Take reasonable steps to insure professional ethical conduct and competent clinical performance on the part of medical staff members, including initiating investigations and initiating and pursuing corrective action, when warranted.
G. Make proposed recommendations on medico-administrative and Hospital management matters to the Board through the President.
H. Inform the Medical Staff of the accreditation program and the accreditation status of the Hospital.
I. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs
J. Represent and act on behalf of the Medical Staff, subject to such limitations as may be

imposed by these Bylaws, and serve as liaison between the Medical Staff and the President and Board.

K. Act on behalf of the Medical Staff on all matters in the intervals between medical staff meetings.

L. Implement the policies of the Medical Staff.

10.4-3 MEETINGS

The MEC shall meet as required to fulfill its obligations to the Medical Staff and maintain a permanent record of its proceedings and actions.

10.4-4 MEC – MEDICAL STAFF CONFLICT MANAGEMENT PROCESS

In the event that a majority of the voting members of the organized medical staff each signed a petition or otherwise evidence disagreement with any action taken by the Medical Executive Committee including, but not limited to, any proposed Bylaw, rule, regulation or policies, these members can require that the conflict management process under this Article be followed:

The petition should clearly state the basis of the disagreement and may include any other information by way of additional explanation to medical staff members. The petitioner must acknowledge that they he/she has read the petition and all attachments, if any, in order for their signature to be considered valid.

Once the conflict management threshold has been achieved, the petition and any attachments and a list of petitioners shall be forwarded to the Medical Executive Committee. Within thirty (30) days of the Medical Executive Committee's receipt of the petition, a meeting between representatives of both the Medical Executive Committee and the petitioners shall be scheduled as determined by the Chief of the Medical Staff. The parties shall act in good faith and shall take reasonable steps to resolve the conflict in question.

If the Medical Executive Committee and the petitioners are able to resolve the conflict, the resolution shall be submitted to the voting members. If the voting members approve the proposed resolution, the proposal will be forwarded to the Board for its review and consideration.

Should the parties fail to reach resolution, or if the voting members do not approve any proposed solution agreed by the petitioners and Medical Executive Committee, the petition and all accompanying materials will be forwarded to the Board for its review and consideration. The decision of the Board shall be final and shall not serve as a basis for conflict management under the Hospital Bylaws.

If, on the other hand, the voting members accept the conflict resolution as proposed by the petitioners and the Medical Executive Committee, the resolution, the initial petition and all accompanying materials shall be forwarded to the Board for its review and consideration. If approved by the Board, the decision shall be final. If not approved, the Medical Executive Committee and/or the petitioning representatives of the Medical Staff shall each have the option of requesting that the conflict management process under the Hospital Bylaws be pursued.

Nothing under this section precludes direct communication between an individual member(s) from communicating with the Board of Directors on any rule, regulation or policy already adopted by the organization Medical Staff or the Medical Executive Committee.

10.4-5 REMOVAL OF MEC AUTHORITY

The Medical Staff may, at a regular or special meeting, at which time a quorum is achieved, remove and reassign any of the authority here delegated to the MEC for a stated period of time, for a reason identified, and supported by 2/3 of the voting members at said meeting.

10.5 INVESTIGATIVE COMMITTEE

10.5-1 COMPOSITION

The Investigative Committee shall consist of a minimum of three (3) members of the Active Medical Staff, none of whom may be members of the MEC.

10.5-2 DUTIES

The duties of the Investigative Committee are to:

A. Investigate complaints when directed by the MEC and/or Board;
B. Conduct any investigations necessary to establish the facts.

10.5-3 MEETINGS

The Investigative Committee shall meet as needed to fulfill the duties of the committee.

10.6 CREDENTIALS COMMITTEE

10.6-1 COMPOSITION

The Credentials Committee is appointed by the Chief of Staff and shall consist of primary care and specialist physicians with preference given to previous chiefs of staff. The Medical Director of JCH is also a member of the Credentials Committee.

10.6-2 DUTIES

The duties of the Credentials Committee are to:

A. Review and evaluate the qualifications of each practitioner applying for Medical Staff appointment and clinical privileges and make a report and recommendations for appointment and/or clinical privileges to the MEC;
B. Periodically review information regarding the competence of practitioner and, as a result of such reviews, make recommendations for the granting of continued clinical privileges and reappointments;
C. Investigate, review and report on matters referred by the Chief of Staff, the MEC, or department chairs regarding the qualifications, conduct, professional character or competence of any applicant, medical staff member, and;
D. Submit periodic reports to the MEC on its activities and the status of pending applications.

10.6-3 MEETINGS

The Credentials Committee shall meet as required to fulfill its obligations to the Medical Staff and maintain a permanent record of its proceedings and actions

10.7 JEFFERSON COUNTY HOSPITAL (JCH) COMMITTEE

10.7-1 COMPOSITION

The JCH Committee shall consist of active medical staff members with privileges to practice at Jefferson County Hospital. A Medical Director and Vice Medical Director of the JCH Committee shall be elected from the membership of the committee annually by majority vote of the committee with approval by the Chief of Staff and MEC. The Medical Director of the JCH Committee shall also serve on the MEC pursuant to Section 10.4-1 and the Credentials Committee pursuant to Section 10.6-1.

Allied Health Practitioners with privileges at JCH may attend JCH Committee meetings and serve in an advisory capacity for review of new and biennial review of existing patient care policies (§485.635(a)(2); §485.635(a)(4)).

10.7-2 DUTIES

The duties of the JCH Committee are to:

A. Propose and review policies and procedures, orders sets, protocols and drug formulary specific to JCH;
B. Develop criteria for use in evaluating patient care at JCH, collecting and analyzing data and information about the quality of patient care so that current performance levels, patterns or trends can be identified. This includes, but is not limited to JCH quality measures, utilization review, patient safety, infection control, peer review and environmental safety;
C. Assist in activities related to maintenance of accreditation;
D. Assist in the development of disaster plans and protocols for JCH;
E. Evaluate and recommend action to the MEC regarding JCH strategic planning and capital budgeting.
F. Report and make recommendations where appropriate to the MEC of all its activities.

10.7-3 MEETINGS

The JCH Committee shall meet as required to fulfill its obligations to the Medical Staff and maintain a permanent record of its proceedings and actions.

10.8 PARTICIPATION ON INTERDISCIPLINARY HOSPITAL COMMITTEES

Medical staff functions and responsibilities relating to liaison with the Board and the Hospital administration, Hospital accreditation, disaster planning, infection control, facility and services planning, and financial management shall be discharged in part by various officers and organizational components of the Medical Staff as described in these Bylaws and in part by the appointment of medical staff members to any Hospital committees which shall be made and such committees shall operate in accordance with the

Hospital Bylaws and the written policies of the Hospital and of the Medical Staff.

10.9 COMMITTEES OF THE STAFF

10.9-1 COMPOSITION AND APPOINTMENT

A medical staff committee established to perform one or more of the functions required by these Bylaws shall be composed of members of the Medical Staff and may include, where appropriate, AHPs and representation from hospital administration, nursing service, medical records service, pharmaceutical service, social service, and such other Hospital departments as are appropriate to the function(s) to be discharged. Except in the case of the, JCH Committee, the Credentials Committee and the Investigative Committee, committee members shall be appointed by the Chief of Staff, with those administrative staff appointees being appointed by the Presidents subject to the approval of the Chief of Staff. Members of the Credentials Committee as well as the Investigative Committee shall be appointed by the Chief of Staff subject to the approval of the Medical Staff and Board. The Chief of Staff shall, with the approval of the MEC, select committee chairmen where not provided for in these Bylaws. The Chief of Staff and the Presidents, or their respective designees, shall serve as ex-officio members of all committees unless otherwise expressly provided. The Presidents or their appointed designee shall serve as recording secretary for all medical staff committees. The Presidents and their appointees may only vote on those committees designated as interdisciplinary hospital committees as outlined in Section 11.6 of these Bylaws.

10.9-2 TERM AND PRIOR REMOVAL

Unless otherwise specifically provided, a Medical Staff committee member shall continue as such until the end of the Medical Staff Year and until their successor is elected or appointed, unless he shall sooner resign or be removed from the committee. A Medical Staff committee member, other than one serving as ex-officio, may be removed by a majority vote of the MEC. An administrative staff committee member shall serve for a term equivalent to that of a Medical Staff committee member and until their successor is elected or appointed, unless he shall sooner resign or be removed from the committee. An administrative staff committee member may be removed by action of the Presidents or majority vote of the MEC.

10.9-3 VACANCIES

Unless otherwise specifically provided, vacancies on any medical staff committee shall be filled in the same manner in which the original appointment to such committee is made.

10.9-4 MEETINGS

A medical staff committee established to perform one or more of the medical staff functions required by these Bylaws shall meet as often as is necessary to discharge its assigned duties, but no less often than quarterly. A permanent record of the proceedings and actions of all Medical Staff committees shall be maintained. Medical staff committees may meet in executive session without President with prior approval of the MEC and with a report to the Board as to the reason for the executive session.

10.10 ORGANIZED HEALTH CARE ARRANGEMENT

10.10.1 The Hospital and its medical staff members operate as an OHCA, in that they provide direct patient care services through clinically integrated settings (including but not limited to in-patient, outpatient and hospital clinic settings).

10.10.2 Members of the OHCA treating patients at any such clinically integrated settings shall use a joint notice of privacy policies and joint acknowledgment of receipt of such notice, as designated by the Hospital on behalf of the OHCA and consistent with the HIPAA Privacy Standards, 45 C.F.R. Parts 160 and 164.

10.10.3 Each Member of the OHCA shall abide by the terms of the joint notice of privacy practices, and all other hospital policies and procedures related to compliance with the HIPAA privacy standards, with respect to protected health information (PHI) created or received by such Member as part of its participation in such OHCA.

10.10.4 Each member of the OHCA shall take reasonable steps to ensure the privacy and security of all patient protected health information (PHI), including PHI created, used, transmitted or maintained as part of this OHCA, and shall use and disclose only the minimum necessary PHI to meet a particular need for treatment, payment or health care operational purposes.

10.10.5 The designation of such OHCA among the Hospital and its medical staff members is solely for the purposes set forth above to facilitate compliance with the privacy standards, and shall not, in any way, alter the independence of the OHCA members for all other purposes or create any liability of a member for the independent judgment, conduct or actions of the other members of the OHCA.

10.10.6 Failure of any Member of the OHCA to comply with the requirements of the OHCA, as set forth above, may subject such Member to corrective action as provided in Article VIII of these Medical Staff Bylaws.

ARTICLE XI: MEETINGS

11.1 MEDICAL STAFF YEAR

For purposes of the business of the Medical Staff, the Medical Staff Year will commence each January 1 and expire on the following December 31.

11.2 GENERAL STAFF MEETINGS

11.2-1 REGULAR MEETINGS

The Medical Staff shall hold medical staff meetings as required to fulfill its obligations and/or as determined by the MEC. The regular medical staff meeting immediately prior to the end of each medical staff year constitutes the annual meeting at which the election of officers for the following medical staff year shall be conducted.

11.2-2 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the MEC, or shall be called by the Chief of Staff within two (2) days after receipt of a written request of at least twenty-five percent (25%) of the members of the Active Medical Staff in good standing, except in the case of the removal of officers pursuant to Section 9.6, 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.

11.2-3 ORDER OF BUSINESS AND AGENDA

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

A. Review and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting;
B. Administrative reports from the President, the Chief of Staff, governing Board members, and committees;
C. The election of officers and of representatives to medical staff committees, when required by these Bylaws;
D. Reports by responsible officers and committees on the findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients and on the utilization management activities of the Medical Staff and on the fulfillment of the other required medical staff functions.
E. Recommendations for improving patient care within the Hospital; and
F. New business.

11.3 COMMITTEE MEETINGS

11.3-1 REGULAR MEETINGS

Committees 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.

11.4 NOTICE OF MEETINGS

Written notice stating the place, day, and hour of any general medical staff meeting, of any special meeting, or of any regular committee meeting not held pursuant to resolution shall be delivered either personally or by mail or electronically to each person entitled to be present thereat not less than two (2) days nor more than thirty (30) days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting. The Presidents shall be entitled to attend all regular and special meetings of the Medical Staff and shall receive notice as required in this section, except with prior approval of the MEC and with a report to the Board as to the reason, the Presidents may be excluded under special circumstance.

11.5 QUORUM

11.5-1 GENERAL STAFF MEETINGS

A quorum is constituted by those present of the Active Medical Staff Members at any regular or special meeting for the transaction of all business.

11.5-2 COMMITTEE MEETINGS

A quorum is constituted by any voting members present except in the case of the MEC which requires the presence of fifty percent (50%) of the voting members for a quorum. A quorum for the Investigative Committee requires all voting members to be present. Ex-officio members shall not be counted in determining the presence of a quorum.

11.6 MANNER OF ACTION

Except as otherwise specified in these Bylaws, the action of a majority of the members present and voting at a meeting at which a quorum is present, shall be the action of the group.

11.7 MINUTES

Minutes of all meetings shall be prepared by the Presidents or their appointed designee and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be approved by the attendees, forwarded to the MEC, and made accessible to the Medical Staff. A permanent file of the minutes of each meeting shall be maintained.

11.8 MEETING ATTENDANCE

11.8-1 REGULAR ATTENDANCE

It is recommended that each member of the Active Medical Staff attend:

A. At least seventy-five percent (75%) of all medical staff meetings duly convened pursuant to these Bylaws; and

B. At least seventy-five percent (75%) of all meetings of each committee of which he is a

member.

11.8-2 COURTESY AND CONSULTING

Members of the Courtesy and Consulting medical staff shall not be required to attend meetings, unless the MEC chooses to specifically require attendance because the medical staff member cannot demonstrate active participation on the Active Medical Staff at another hospital requiring performance improvement activities similar to those required by this Hospital. It is expected that they will attend and participate in these meetings unless unavoidably prevented from doing so.

11.8-3 SPECIAL APPEARANCE

A medical staff member whose patient's clinical course of treatment is scheduled for discussion at a regular committee or medical staff meeting and whose attendance is specifically desired, shall be given written notice of the matter and of the time and place of the meeting at least five (5) days prior to the meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, special notice shall be given and shall include a statement of the issue involved and that the medical staff member's appearance is mandatory. Failure of a medical staff member to appear at any meeting with respect to which they were given such special notice shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the medical staff member's clinical privileges as the MEC may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the MEC, or the Board, or through corrective action if necessary.

ARTICLE XII: CONFIDENTIALITY, IMMUNITY AND RELEASES

12.1 CONFIDENTIALITY OF INFORMATION

Information with respect to any applicant or medical staff member submitted, collected, or prepared by a hospital representative or any representative of any other health care facility or organization or medical staff for the purpose of evaluating and improving the quality and efficiency of patient care, (including but not limited to studies for the purpose of reducing morbidity and mortality, contributing to teaching or clinical research, determining that health care services are professionally indicated or were performed in compliance with the applicable standard of care, or establishing and enforcing guidelines to keep health care costs within reasonable bounds) shall, to the fullest extent permitted by the Peer Review Statute and other applicable law, be confidential and shall not to the fullest extent permitted by law be disseminated to anyone other than a representative engaged in an official authorized activity for which the information is needed nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's record. Reports of actions taken pursuant to the Bylaws and Fair Hearing Plan shall be made by the President to such governmental agencies as may be required by law.

12.2 PRIVILEGES AND IMMUNITIES

The Board and any committees of the Medical Staff and/or of the Board which conduct peer review processes, hereby constitute themselves as Professional Review Bodies as defined in the Act and in the Oklahoma Act. Each Professional Review Body hereby claims all privileges and immunities afforded to it by said state and federal statutes. Any action taken by a Professional Review Body pursuant to these Bylaws or the Fair Hearing Plan shall be in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the Hospital) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any applicant or medical staff member, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

12.3 IMMUNITY FROM LIABILITY

12.3-1 PERSONS PROTECTED

By applying for and/or accepting appointment to the Medical Staff and by applying for, accepting and/or exercising clinical privileges within the Hospital, each applicant and medical staff member extends absolute immunity to, and releases from all claims, damages and liability whatsoever:

A. The Hospital and any hospital representative for any action taken or statement or recommendation made by any hospital representative within the scope of their duties as a hospital representative in compliance with the Bylaws and Fair Hearing Plan, including disclosures made to other health care facilities pursuant to Section 12.1 above.

B. Any third party for releasing or disclosing information, including otherwise privileged or confidential information, to any hospital representative concerning any former or current applicant or medical staff member unless such information is false and the third party providing it knew it was false.

12.3-2 ACTS COVERED

The immunity provided by Section 12.3 shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Hospital's activities, including, but not limited to:

A. Applications for appointment and/or clinical privileges;
B. Periodic reappraisals undertaken for reappointment or for changes in clinical privileges;
C. Evaluating requests for changes in medical staff category or clinical privileges;
D. Corrective action;
E. Hearings and appellate reviews;
F. Patient care audits;
G. Medical care evaluations;
H. Utilization reviews;
I. Other hospital, staff, department, service, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct;
J. Matters or inquiries concerning the credentials of any applicant or medical staff member;
K. Matters directly or indirectly affecting patient care or the efficient operation of the Hospital;
L. Reports to the National Practitioner Data Bank established pursuant to the Act, and;
M. Reports for criminal background inquiries.

12.4 RELEASES

Each applicant and medical staff member shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this article and such releases or copies thereof may be submitted to third parties from whom information is sought. Execution of such releases is not a prerequisite to the effectiveness of this article.

12.5 CUMULATIVE EFFECT

The provisions in these Bylaws, the Fair Hearing Plan and in application and request forms relating to authorizations and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

12.6 COMMENCEMENT AND TERMINATION OF PROCESS

A peer review process is deemed to commence (i) with respect to a potential corrective action, upon receipt of the first complaint or expression of the first concern regarding any applicant or medical staff appointee; (ii) with respect to a credentialing process, upon the first contact by the Hospital with such applicant or proposed applicant; and (iii) for other peer review processes, as specified by the applicable hospital representatives. All concerns regarding a medical staff member's quality of patient care identified by a

hospital employee or another medical staff member will be brought to the appropriate medical staff committee for the evaluation of the need for peer review. Any and all medical staff members involved in the quality of care concern will be notified by the committee chairperson at the commencement of the peer review process, and be kept informed of the progress and resolution of the concern. The quality assurance and other on-going quality of care monitoring by the Hospital of medical staff appointees shall constitute continuous peer review processes. A peer review process will be deemed to have terminated (i) as to a proposed corrective action, when the concerns regarding the particular applicant or medical staff appointee have been resolved or a final determination has been made respecting such applicant or medical staff appointee; (ii) as to a credentialing process, upon a final determination by the Board regarding the application for appointment and/or reappointment; and (iii) for other peer review processes, as specified by the applicable hospital representatives. The commencement and termination of particular peer review processes shall be documented in a manner designed to achieve maximum protection for peer review information under the Peer Review Statute.

12.7 PEER REVIEW INFORMATION

All peer review information and any other documents utilized during a peer review process shall be maintained in accordance with the Hospital's record retention policy pertaining to such information. No hospital patient charts will be sent for outside consultant peer review without the direction and knowledge of the medical staff committee conducting the peer review and the medical staff member involved.

ARTICLE XIII: GENERAL PROVISIONS

13.1 STAFF RULES AND REGULATIONS AND POLICIES

Subject to approval by the Board, the Medical Staff shall adopt such Rules and Regulations, and policies as may be necessary to implement more specifically the general principles found in these Bylaws. The provisions of Article XIV of these Bylaws are applicable to the adoption and amendment of the Rules and Regulations, and policies except that medical staff action may occur at any regular meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by majority vote of those present who are eligible and qualified to vote. The Rules and Regulations and policies may be reviewed as needed, but not less often than every three (3) years, for the purpose of revising them as necessary to reflect current practice with respect to medical staff organization and functions.

In the event that the hospital receives a written notice, demand or other similar communication from a governmental or similar entity or if the Hospital is put on notice that it needs to amend a rule or regulation of the Medical Staff in order to comply with any law or regulation, which change cannot be accomplished within the time frames provided within the Bylaws, the Chief of Staff will call an emergency Medical Staff meeting. Copies of any notice or materials requiring the urgent amendment, if not otherwise confidential, will be submitted along with the written notice. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendment will remain in effect. If there is conflict over the provisional amendment, the process for resolving conflict between the Medical Staff and the Medical Executive Committee is implemented. At the next regularly scheduled medical staff meeting (or emergency meeting if deemed necessary) the Medical Staff shall have the opportunity to comment on and or make motions to amend or rescind the previously approved rule or regulation of the Medical Staff.

Where the urgent change only involves a change to a policy of the Medical Staff, the approval process referenced above does not apply but a copy of the policy amendment will be sent to all members of the Medical Staff. At the next regularly scheduled medical staff meeting, the Medical Staff shall have the opportunity to comment on and or make motions to amend or rescind the policy.

13.2 STAFF DUES

The MEC, with the approval of the Active Medical Staff, will establish the amount and manner of disposition of annual dues, if any. Dues are payable at the beginning of each new medical staff year. Failure, unless excused by the MEC for good cause, to render payment within two (2) months of the start of the new medical staff year shall, after special notice of the delinquency, result in summary suspension of medical staff membership (including all prerogatives) and clinical privileges until the delinquency is remedied. The medical staff member shall not be entitled to the procedural rights provided in the Fair Hearing Plan.

13.3 PROFESSIONAL LIABILITY INSURANCE

Each medical staff member granted clinical privileges in the Hospital shall maintain in force professional liability insurance in not less than the minimum amounts, as from time to time may be determined by resolution of the Board after consultation with the MEC, or provide other proof of financial responsibility

in such manner as the Board may from time to time establish.

13.4 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with medical staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be subject to adoption by the Board after considering the advice of the MEC.

13.5 CONSTRUCTION OF TERMS AND HEADINGS:

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

13.6 TRANSMITTAL OF REPORTS

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

13.7 DESIGNEES TO PERFORM FUNCTIONS OF THE PRESIDENT

Any responsibility assigned, or authority granted, to the President may be fulfilled or exercised by another administrative official of the Hospital, designated by the President or the Board to perform such function, except as otherwise provided by the Board or in the Hospital Bylaws.

13.8 GOOD STANDING

The prerogatives and rights provided by these Bylaws to medical staff members to vote at medical staff meetings, to be nominated for and to hold Medical Staff office, or serve as a member of the MEC, and to serve as an officer or committee chairman, shall be limited to medical staff members in good standing.

13.9 RULES OF ORDER

The meetings of the Medical Staff and all committees shall be conducted in accordance with Roberts Rules of Order.

13.10 SEVERABILITY

In case any provision in these Bylaws shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

13.11 GOVERNING LAW

These Bylaws shall be governed by, and construed in accordance with the Act and, to the extent not inconsistent therewith, the Oklahoma Act, and to the extent not so governed, with the other laws of the State of Oklahoma without giving effect to its conflict of laws principles.

13.12 COUNTING OF DAYS

In any instance in which the counting of days is required in the Bylaws, the Fair Hearing Plan or the Rules and Regulations in connection with the giving of notice or for any other purpose, the day of the event shall

not count, but the day upon which the notice is given shall count. In any case where the date on which some action is to be taken, notice given or period expired occurs on a holiday, a Saturday or a Sunday, such action shall be taken, such notice given or such period extended to the next succeeding Monday, Tuesday, Wednesday, Thursday or Friday, which is not a holiday. For the purposes of this Section, the term "holiday" shall mean such days as are commonly recognized as holidays by the City of Duncan, Oklahoma.

13.13 NOTICES

All notices, requests, demands, reports, written statements and other communications required or permitted to be given to any applicant or medical staff member in the Bylaws or the Fair Hearing Plan shall be deemed to have been duly given, if in writing and delivered personally, electronically or deposited in the United States certified or registered mail, postpaid, return receipt requested, to the address of the applicant or medical staff member on their application or to their last known address according to the books and records of the Hospital.

13.14 CROSS REFERENCES

Throughout the document, cross references are made to other sections of this document and to other related documents, such as the Fair Hearing Plan. By reason of amendments, it is possible that cross references may not always be appropriately changed to conform to the intentions expressed in this or related documents. In such circumstances, such cross references shall be interpreted as applying (i) to the section or subsection designated at the time originally drafted, if such section or subsection is still included in the appropriate document, even though it may have been renumbered or amended, or (ii) to the section or subsection replacing such cross referenced section or subsection, if the content of such replacement section or subsection is such as to be consistent with the original sense of the cross reference.

ARTICLE XIV: ADOPTION AND AMENDMENT OF BYLAWS

14.1 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

The Medical Staff shall have the initial responsibility and authority to formulate and recommend to the Board Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community of the Medical Staff as needed, but not less often than every three (3) years for the purpose of revising the Bylaws as necessary to reflect current practice with respect to Medical Staff and its functions.

14.2 METHODOLOGY

The Medical Staff Bylaws shall be adopted, amended, or repealed by the following combined action:

14.2-1 MEDICAL STAFF

The affirmative vote of a majority of the Medical Staff Members eligible to vote on this matter at a meeting at which a quorum is present, provided a copy of the proposed Bylaws and/or alterations accompanied the meeting notice and was presented at the preceding regular meeting.

14.2-2 BOARD

The affirmative vote of a majority of the Board.

14.3 DISSEMINATION OF INFORMATION

If significant changes are made in the Bylaws, members of the Medical Staff and other individuals who have delineated clinical privileges will be provided a copy of these revisions at the time of reappointment, or earlier if deemed necessary by the MEC.

14.4 COMPLIANCE AND COMPATABILITY

The Medical Staff Bylaws, Rules and Regulations, and Policies, the Governing Board Bylaws, and the Hospital policies shall be compatible with each other and shall be compliant with law and regulation.

14.5 UNIFIED MEDICAL STAFF PROVISIONS

14.5-1 ADOPTION OF A UNIFIED MEDICAL STAFF

If the Governing Board elects to adopt a single unified Medical Staff that includes the Hospital, the voting members of the Medical Staff may approve or opt out of the unified Medical Staff structure by conducting a vote in accordance with the process outlined in Section 14.1-14.2 for amending these Bylaws.

14.5-2 BYLAWS, POLICIES AND RULES AND REGULATIONS OF THE UNIFIED MEDICAL STAFF

Upon approval of a unified Medical Staff structure, the unified Medical Staff will adopt Medical Staff bylaws, policies and rules and regulations that:

A. Take into account the unique circumstances of each participating hospital, including any significant differences in the patient populations that are served and the clinical services that are offered; and

B. Address the localized needs and concerns of the Medical Staff members at each of the participating hospitals.

14.5-3 OPT-OUT PROCEDURES

No sooner than two (2) years after the effective date of a unified medical staff, and not more than once every five (5) years thereafter, a vote to opt out of the unified medical staff may be taken. To hold a vote to opt out, a petition signed by one third (1/3) of the eligible members of the medical staff must first be presented to the MEC and the Governing Body. Within sixty (60) days following the Governing Body's receipt of the petition and it's verification that the requisite number of bona fide signatures are present, the Governing Body shall direct the MEC to hold an opt-out vote at a meeting held for that purpose. The MEC shall provide thirty (30) days advance notice to each eligible medical staff member. The opt-out vote shall occur by written ballot of those eligible members present at the meeting. If the there is a majority vote for the affirmative to opt out, then the Governing Body will establish a separate medical staff.

ADDENDUM A: FAIR HEARING PLAN OF THE MEDICAL STAFF OF DRH HEALTH

Effective Date: January, 1988

ARTICLE I: DEFINITIONS

1.1 DEFINITIONS:

Whenever used in this Fair Hearing Plan, the terms listed in the Definition Section of the Bylaws shall have the meanings stated therein unless the context should clearly require otherwise. Such meanings shall be equally applicable to the singular and plural forms and, where applicable, to the masculine and feminine genders of the terms defined or used herein.

ARTICLE II: FAIR HEARINGS

2.1 RIGHT TO HEARING:

2.1-1 ADVERSE RECOMMENDATIONS OR ACTIONS:

Unless waived, an Applicant or Medical Staff Member shall be entitled to a hearing if any Professional Review Body proposes (i) to make a recommendation that any of the following adverse actions be taken with respect to them; or (ii) to take any of the following adverse actions without a prior adverse recommendation of any Professional Review Body.

A. Denial of a completed application for initial appointment to the Medical Staff, except where (i) the application is not acceptable under the requirements set forth in Article VI of the Bylaws.

B. Denial of a completed application reappointment, except where (i) the application is not acceptable under the requirements set forth in Article VI of the Bylaws.

C. Summary suspension or termination from the Medical Staff under Section 8.2 of the Bylaws.

D. Revocation or termination of appointment to the Medical Staff, except where continued appointment to the Staff was contingent upon the continuance of a contractual relationship with the Hospital.

E. Denial of requested advancement or modification of Medical Staff category, except for any denial resulting from a failure to meet the minimum objective criteria for the requested category.

F. Reduction in Medical Staff category, other than any change in category resulting from a failure to meet the minimum objective criteria for a particular category.

G. Denial of requested clinical privileges or requested change in clinical privileges, except where the Applicant or Medical Staff Member fails to meet the minimum objective criteria for the requested privileges.

H. Reduction in, restriction of, or failure to renew clinical privileges, other than (i) a temporary restriction under Section 8.1-5 of the Bylaws; or (ii) where the Medical Staff Member no longer meets the minimum objective criteria for such privileges.

I. Revocation or suspension (summary or otherwise) of clinical privileges, other than (i) a temporary suspension under Section 8.1-5 of the Bylaws; or (ii) where the Medical Staff Member no longer meets the minimum objective criteria for such privileges.

J. Imposition of consultation which restricts the clinical privileges of the Medical Staff Member or the delivery of professional services to patients.

K. Imposition of probation which restricts the clinical privileges of the Medical Staff Member or the delivery of professional services to patients.

L. Any other action or recommendation "adversely affecting" (as such term is defined in Section 431(1) of the Act) any Applicant or Medical Staff Member. This Section 2.1-1 shall control in the event of any conflict between this Section 2.1-1 and 2.1-2.

2.1-2 ACTIONS NOT GIVING RISE TO A HEARING:

A Professional Review Body shall not be deemed to have made a proposal for an adverse recommendation or action, or to have made such a recommendation or to have taken such an action, and a hearing right under this Article II shall not have arisen in any of the following circumstances:

A. The appointment of an ad hoc investigation committee;

B. The conduct of an investigation into any matter;

C. The restriction or suspension of a Medical Staff Member's Clinical Privileges for a period of no longer than seven (7) days while an investigation is pending;

D. The formulation and presentation of any preliminary report of any Investigative Committee or ad hoc investigation committee to the President or to MEC;

E. The making of a request or issuance of a directive to an Applicant or Medical Staff Member to appear at an interview or conference before the Credentials Committee, the Investigative Committee, any ad hoc investigation committee, the President, the Board or any other Professional Review Body in connection with any investigation prior to a proposed adverse recommendation or action;

F. The denial of or refusal to accept an application for initial appointment or reappointment to the Medical Staff where the application is incomplete or where the Applicant does not meet the requirements set forth in Article VI of the Bylaws;

G. The denial or revocation of temporary privileges under Section 7.6-3 of the Bylaws;
H. The appointment of a newly-appointed Medical Staff Member during the Focused Professional Practice Evaluation (FPPE) period and the imposition of monitoring and consultation required for all Staff Members during the FPPE period;
I. Temporary restriction or suspension of Clinical Privileges under Section 8.15 of the Bylaws;
J. Automatic termination under Section 8.3 of the Bylaws;
K. The imposition of supervision or observation on a Medical Staff Member which supervision or observation does not restrict the Clinical Privileges of the Medical Staff Member or the delivery of professional services to patients;
L. The issuance of a letter of warning, admonition or reprimand;
M. Corrective counseling;
N. A recommendation that the Medical Staff Member be directed to obtain retraining, additional training, or continuing education;
O. Any change in Medical Staff category or clinical privileges resulting from the failure of a Medical Staff Member to meet the minimum objective criteria for a specific category or specific clinical privileges;
P. The adoption by the Hospital of an exclusive contract or other exclusive arrangement for a particular service or services pursuant to Section 3.4-3 of the Bylaws or the expiration or other termination of a contract pursuant to Section 3.6-3 of the Bylaws.
Q. Any recommendation or action not "adversely affecting" (as such term is defined in Section 431(1) of the Act) any Applicant or Medical Staff Member and any other action or recommendation not listed in Section 2.1-2 of this Fair Hearing Plan.

A hearing right provided as to a proposed adverse recommendation or action satisfies the requirements for a hearing right as to the final recommendation and the adverse action which was the subject of the proposed adverse recommendation or action.

2.1-3 WHEN DEEMED DVERSE:
A proposal for recommendation or action adverse to an Applicant or Medical Staff Member is deemed to have been made at the time that the President is notified that the adverse recommendation or action has been approved for issuance to the Board by the Credentials Committee or any other

Professional Review Body.

2.2 NOTICE OF ADVERSE RECOMMENDATION OR ACTION:
The President shall promptly give the Applicant or Medical Staff Member Special Notice of a proposed adverse recommendation or action described in Section 2.1-1 of this Fair Hearing Plan. The notice shall:

A. Advise the applicant or Medical Staff Member of the proposed adverse recommendation or action.
B. Include a statement of the reasons for the proposal of adverse recommendation or action, except that in the case of a proposal for denial of an initial application for staff appointment such notice shall be sufficient if it contains a statement of the areas in which the applicant's qualifications were found deficient.
C. Inform the applicant or Medical Staff Member of their right to request a hearing pursuant to the provisions of the Fair Hearing Plan.
D. Inform the applicant or Medical Staff Member that if a hearing is desired it must be requested no later than thirty (30) days from receipt of the notice.
E. Include a brief summary of the applicant's or Medical Staff Member's rights under the Fair Hearing Plan.
F. State that failure to request a hearing within that time period and in the proper manner constitutes a waiver of rights to any hearing or a appellate review on the matter that is the subject of the notice.

2.3 REQUEST FOR HEARING:
An applicant or Medical Staff Member who is affected by a proposed adverse recommendation or action may request a hearing before a Hearing Committee of the Medical Staff. The request for a hearing must be given in writing and either delivered personally or sent by certified mail, return receipt requested, to the President no later than thirty (30) days after Special Notice of the proposed adverse recommendation or action was given to the applicant or Medical Staff Member.

2.4 WAIVER BY FAILURE TO REQUEST A HEARING:
An applicant or Medical Staff Member who fails to request a hearing in the manner specified in Section 2.3 waives their right to any hearing and appellate review to which he might have been entitled. A waiver of hearing right as to an adverse recommendation also waives a hearing right for the adverse action recommended.

2.4-1 AFTER ADVERSE ACTION BY THE OARD:
A waiver constitutes acceptance of the action which then becomes the final

decision of the Board. A copy of the written decision of the Board shall be sent by the President to the affected applicant or Medical Staff Member.

2.4-2 AFTER PROPOSED ADVERSE RECOMMENDATION BY PROFESSIONAL REVIEW BODY

A waiver of a hearing request following a proposed adverse recommendation by a Professional Review Body constitutes acceptance of the Professional Review Body's proposed adverse recommendation, when then becomes and remains effective pending the decision of the Board. The Board shall consider the proposed adverse recommendation at its next regular meeting following the waiver. A copy of the written decision of the Board shall be sent by the President to the affected applicant or Medical Staff Member. The Board's action has the following effect:

A. If Board is in Accord with Professional Review Body's Proposed ` Recommendation: If the Board's action accords in all respects with Professional Review Body's proposed recommendation, it then becomes effective as the decision of the Board. A copy of the written decision of the Board shall be sent by the President to the affected applicant or Medical Staff Member.

B. If Board Changes Professional Review Body's Proposed Recommendation: If, on the basis of the same information and material considered by the Professional Review Body in formulating its recommendation, the Board proposes different action, the matter shall be submitted to a joint conference as provided in Section 7.14 of this Fair Hearing Plan, and Board's action shall be deferred until the joint conference recommendation is provided to the Board. The Board's action after receiving the joint conference recommendation becomes the decision of the Board shall be sent by the President to the affected applicant or Medical Staff Member.

2.5 ADDITIONAL INFORMATION OBTAINED FOLLOWING WAIVER:

If a hearing or appellate review of a Professional Review Body's proposed adverse recommendation is waived by an applicant or Medical Staff Member, and prior to final action by the Board additional information is submitted by the applicant, or Medical Staff Member or an individual or group functioning, directly or indirectly on their behalf, the additional information shall not be considered, unless the applicant or Medical Staff Member demonstrates to the satisfaction of the Professional Review Body or the Board, as applicable, that the information was not reasonably discoverable in time for the presentation to and consideration by the party taking

the initial adverse action or by the Hearing Committee if the applicant or Medical Staff Member's waiver is in connection with an appellate review.

2.5-1 WHEN RECEIVED BY THE BOARD:
If the Board acquires or is informed of additional information that is directly relevant to the matter at issue, but was not available to or considered by the Professional Review Body, the Board may, in its sole discretion, refer the matter back to the Professional Review Body for reconsideration within a set time limit.

A. Professional Review Body Follow-Up Recommendation Adverse:
A proposed adverse recommendation by the Professional Review Body following reconsideration is deemed a new adverse recommendation under Section 2.1 and the matter shall proceed as such.

B. Professional Review Body Reconsideration Recommendation Favorable:
A proposed favorable recommendation by the Professional Review Body following reconsideration shall be immediately forwarded to the Board by the President. The effect of Board action is as follows:

1. Board Favorable: Favorable Board action on a favorable proposed recommendation by the Professional Review Body shall become the decision of the Board.
2. Board Adverse: If the Board proposes to take an adverse action, the matter shall be submitted to a joint conference as provided in Section 7.14. Favorable Board action after receiving the joint conference recommendation shall become the decision of the Board. Adverse board action after receiving the joint conference recommendation shall be deemed a new adverse action under Section 1.1 and the matter shall proceed as such.

ARTICLE III: HEARING PREREQUISITES

3.1 NOTICE OF TIME AND PLACE FOR HEARING:

If an applicant or Medical Staff Member requests a hearing within the thirty (30) day time period specified in Section 2.3 of the Fair Hearing Plan, the President shall give the applicant or Medical Staff Member Special Notice of the place, time and date of the hearing, which date shall be not less than thirty (30) days after the date of the Special Notice. The Special Notice shall be accompanied by a copy of this Fair Hearing Plan. The Special Notice shall also (i) list the Medical Staff Members appointed pursuant to Section 3.2 of this Fair Hearing Plan to serve as members of the Hearing Committee, (ii) list the witnesses (if any) expected to testify, a brief summary of their expected testimony arid the exhibits (if any) expected to be introduced at the hearing in support of the adverse recommendation or action, (iii) inform the applicant or Medical Staff Member that they have the right in the hearing to representation by an attorney or other person of their choice, and the duty to advise the President within fourteen (14) days after the notice of hearing is given, of the name and address of any such representative and whether such representative is an attorney, (iv) inform the applicant or Medical Staff Member that they will be required to provide a list of witnesses expected to testify, a brief summary of their expected testimony and exhibits expected to be introduced, and shall have the right to present a written response to the proposed adverse recommendation or action, briefly outlining the position of the applicant or Medical Staff Member, within fourteen (14) days after the notice of hearing is given, and (v) inform the applicant or Medical Staff Member that they have the duty to advise the President within fourteen (14) days after the notice of hearing is given if he or she believes that any Medical Staff Member appointed as a voting member of the Hearing Committee does not meet the criteria for appointment to the Hearing Committee set forth in Section 3.2 of this Fair Hearing Plan.

3.2 APPOINTMENT OF HEARING COMMITTEE:

3.2-1 PROPOSED ADVERSE RECOMMENDATION BY PROFESSIONAL REVIEW BODY:

A recommendation by a Professional Review Body shall be conducted by a Hearing Committee appointed by the President. The President also may appoint a Presiding Officer. The Hearing Committee shall consist of at least three (3) Medical Staff Members who meet the criteria set forth in Section 3.2-3, unless the President determines that such criteria cannot be met by three (3) Medical Staff Members, in which case the President shall appoint a Hearing Committee consisting of fewer than three (3) Medical Staff Members or three (3) physicians or lay persons not connected

with the Hospital.

3.2-2 PROPOSED ADVERSE RECOMMENDATION OR ACTION BY BOARD:
A hearing occasioned by a proposed adverse recommendation or action of the Board shall be conducted by a Hearing Committee appointed by the Chairman of the Board and composed of at least three (3), but not more than five (5) persons. When the issues concern the professional competence or conduct of the applicant or Medical Staff Member, the Hearing Committee shall consist of five (5) persons, at least two (2) of which are active Medical Staff Members, chosen with the concurrence of the Chief of Staff. The Chairman of the Board may appoint a Presiding Officer. All of the Hearing Committee members will be Board members or active Medical Staff Members.

3.2-3 SERVICE ON HEARING COMMITTEE:
The Hearing Committee shall have no voting members (i) who actively participated in initiating or investigating the underlying matter at issue, or (ii) who had responsibility for making the proposal giving rise to a hearing right, or (iii) who are in direct economic competition with the applicant or Medical Staff Member for whom the hearing has been scheduled. If the applicant or Medical Staff Member for whom the hearing has been scheduled advises the President within the 14-day period provided for in Section 3.1 of this Fair Hearing Plan that he or she believes a Medical Staff Member appointed as a voting member of the Hearing Committee does not meet the criteria set forth in this Section 3.2-3, the President shall determine the merit of such contention and if the contention is found to be correct shall appoint a substitute to serve on the Hearing Committee. Failure of an applicant or Medical Staff Member to so advise the President shall be deemed a waiver of any objection to the membership of the Hearing Committee.

At least a majority of the voting members of the Hearing Committee shall be present at each meeting or hearing of the Hearing Committee. Each member of the Hearing Committee will affirm, either verbally or in writing upon the commencement of the hearing, that they have read this Fair Hearing Plan, that they have no reason to doubt their qualifications to serve on the Hearing Committee, that they will perform their responsibilities under the Fair Hearing Plan with impartiality, honesty, and diligence, and that they will make every effort to reach a result based upon the evidence which gives due regard to both fairness to the applicant or Medical Staff Member and to the welfare and safety of patients of the Hospital. A majority of the members of the Hearing Committee who are present at any meeting shall have the power to take

any action or make any decision.

ARTICLE IV: CONDUCT OF HEARING

4.1 PERSONAL PRESENCE:
The personal presence of the applicant or Medical Staff Member who requested the hearing is required. An applicant or Medical Staff Member who fails without good cause to appear and proceed at the hearing shall have waived their rights in the same manner and with the same consequence as provided in Section 2.4.

4.2 PRESIDING OFFICER:
The Presiding Officer may be appointed pursuant to Sections 3.2-1 and 3.2-2 or the Hearing Committee chairman shall be the Presiding Officer. The Presiding Officer shall maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The Presiding Officer may be either a member of the Hearing Committee or another individual, such as a Medical Staff Member, a practitioner of recognized standing who is not a Medical Staff Member, a member of the Board, an arbitrator, a retired judge, or an attorney, who (i) did not actively participate in initiating or investigating the underlying matter at issue, (ii) had no responsibility for proposing the adverse recommendation or action giving rise to the right to a hearing, {iii) is not in direct economic competition with the applicant or Medical Staff Member for whom the hearing has been scheduled, and {iv) is not regularly employed or engaged by any of the parties to the hearing for duties other than acting as Presiding Officer. He or she shall be entitled to determine the order of proceeding during the hearing, to promulgate rules and procedures not inconsistent with the Fair Hearing Plan, to exclude or remove any person who is disruptive to an orderly and professional hearing, and perform the other responsibilities assigned to the Presiding Officer under the Fair Hearing Plan. Service by a member of the Hearing Committee as Presiding Officer shall not in any way prevent such member from full participation in the deliberations and actions of the Hearing Committee. If the Presiding Officer is not a member of the Hearing Committee (as to whom the procedures of Section 3.2 are applicable), then the applicant or Medical Staff Member may advise the President in writing within fourteen (14) days prior to the hearing that he or she does not believe the selected Presiding Officer satisfies the criteria under this Section 4.2; the Hearing Committee shall determine the merits of such contention, and if the contention is found to be correct shall direct the President to select another Presiding Officer.

4.3 REPRESENTATION:
The applicant or Medical Staff Member who requested the hearing shall be entitled

to be accompanied and represented at the hearing by another Medical Staff Member in good standing, by an attorney, or by any other person of their choice. The applicant or Medical Staff Member shall advise the President at least fourteen (14) days prior to the hearing as to the name and address their representative, and whether such representative is an attorney. The President may appoint a Medical Staff Member to represent the position of the Professional Review Body that proposed the adverse recommendation or action, to present the evidence and arguments in support of the proposed adverse recommendation or action. If the applicant or Medical Staff Member who requested the hearing will be represented by an attorney at the hearing, the Professional Review Body that proposed the adverse recommendation or action shall also be represented by an attorney at the hearing; otherwise the Professional Review Body shall not be represented by an attorney at the hearing. Provided, however, that irrespective of whether the parties are represented by an attorney at the hearing, any participant to a hearing pursuant to the Fair Hearing Plan, including without limitation the applicant or Medical Staff Member requesting the hearing, the Professional Review Body, or the Hearing Committee, may consult with an attorney at any time when the hearing is not convened and in session. Provided further, that any participant to a hearing pursuant to the Fair Hearing Plan who is not a participant to the hearing, including without limitation an Appellate Review Body (except when conducting a *de novo* hearing), the MEC, or the Board, may consult with an attorney at any time in the course of proceedings of the hearing procedure. No individual attorney with whom consultation is sought under the provisos of this Section shall be present at the hearing.

4.4 RIGHTS OF PARTIES:

Subject to the provisions of Section 4.10, at the hearing each of the participants shall have the right:

A. To testify on their own behalf.
B. To call, examine, and cross-examine witnesses.
C. To introduce exhibits.

The failure of a hearing participant to list a witness or exhibit pursuant to Section 3.1 or Section 4.5 shall preclude the participant from calling the witness or offering the exhibit at the hearing unless (i) the participant shows that at the time of delivering such lists of witnesses and exhibits, they should not have reasonably expected to be calling the witness or offering the exhibit omitted from such lists or (ii) the Presiding Officer determines that the other hearing participant is not unfairly prejudiced by the calling of said witness' or the offering of said exhibit, and justice otherwise requires it to be allowed.

4.5 WITNESSES AND EXHIBITS:

Not less than fourteen (14) days after the Notice of Hearing was given pursuant to Section 3.1, the applicant or Medical Staff Member shall give to the President (for distribution to the members of the Hearing Committee and the Professional Review Body that proposed the adverse recommendation or action) applicant or Medical Staff Member's listing of the witnesses (if any) expected to testify, a brief summary of their expected testimony and the exhibits (if any) expected to be introduced at the hearing in support of that position. Within ten (10) days after such witness and/or exhibit list is given, the Professional Review Body proposing an adverse recommendation or action shall have the right to amend its witness and/or exhibit list to add witnesses and/or exhibits necessary to respond to or rebut witnesses and/or exhibits listed by the applicant or Medical Staff Member.

4.6 PROCEDURE AND EVIDENCE:

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. The Presiding Officer shall permit admission of any relevant matter upon which reasonable persons customarily rely in the conduct of serious affairs. The Presiding Officer shall have broad discretion in determining whether evidence proposed to be introduced is merely cumulative in nature and does not possess probative value in addition to evidence already admitted, and shall exclude any such cumulative evidence. Each party shall be entitled, prior to or during the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda become part of the hearing record. The Presiding Officer may, but is not required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by them and entitled to notarize documents in the state where the hearing is held. The Presiding Officer shall give effect to the rules of privilege recognized by law, including but not limited to the privilege for communications made by a patient to a licensed practitioner with reference to any physical or supposed physical disease or of knowledge gained by such practitioner through a physical examination of a patient made in a professional capacity, as recognized under Oklahoma law. The Presiding Officer shall also recognize as privileged, to the same extent recognized in judicial proceedings, communications made or documents prepared in anticipation of the hearing provided for in this Fair Hearing Plan. Objections to evidentiary offers may be made and shall be noted in the record. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be received in written form.

4.7 OFFICIAL NOTICE:

The Hearing Committee may in the course of the proceedings indicate that the

Committee will take official notice, either before or after submission of the matter for decision, of any matters as to which the Committee believes there can be no reasonable dispute. Official notice may also be taken of generally accepted technical or scientific facts within the Hearing Committee members' specialized knowledge. Parties present at the hearing must be informed of the matters to be noticed, and those matters must be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute officially noticed matter by evidence or by written or oral presentation of authority, in a manner to be determined by the Hearing Committee. Upon challenge of the propriety of taking such official notice, the Hearing Committee shall set forth in writing and provide the participants to the hearing a brief statement of the basis for such official notice of technical or scientific facts. Any party to the hearing is entitled upon a request made within a reasonable time thereafter to be heard as to the propriety of taking official notice.

4.8 BURDEN OF PROOF:

Whenever a hearing relates to a proposed denial of (i) appointment or reappointment to the Medical Staff; (ii) requested clinical privileges; or (iii) requested advancement in Medical Staff category, the applicant or Medical Staff Member shall have the burden of providing, by clear and convincing evidence, that (i) that they meet the standards for appointment or reappointment to the Medical Staff or for the granting of the clinical privileges or Medical Staff category requested; and (ii) denial of appointment or reappointment, requested clinical privileges or requested advancement in Medical Staff category would be arbitrary and capricious. In all other cases, the Professional Review Body that proposed the adverse recommendation or action shall present supporting evidence, but the Medical Staff Member shall have the burden of proving, by a preponderance of the evidence, that the proposed adverse recommendation or action should be rejected and/or modified, in whole or in part.

4.9 SEQUENCE OF PRESENTATION:

Whenever a hearing relates solely to a proposed denial of (i) appointment or reappointment to the Medical Staff, (ii) requested clinical privileges or (iii) requested advancement in Medical Staff category, the applicant or Medical Staff Member shall present their evidence first. In all other cases the representative of the position of the Professional Review Body shall present their evidence first. After the first party to present evidence has completed, the other party shall present their evidence. The initial party shall then have the opportunity to rebut the evidence presented by the opposing party. The Hearing Committee may in its discretion request or allow opening statements, which if made will be presented by the parties in the same sequence as provided for presentation of evidence.

4.10 REQUESTS FOR INFORMATION OR DOCUMENTS:

Upon request by either party to the hearing, the Presiding Officer may require the other party to provide information or produce documents in its possession, which the Presiding Officer concludes in good faith to be reasonably related to the subject of the hearing and not subject to any privilege as set forth in Section 4.10. If the party who is directed to provide such information or documents fails without good cause to do so, the Hearing Committee shall have wide latitude in drawing adverse inferences against the party who failed to provide the information or documents requested. The Hearing Committee should consider such refusal and weigh the same in making its recommendation pursuant to Section 5.1, and the report of the Hearing Committee shall recite the inferences drawn from the refusal to provide any information or documents under this Section without good cause, and the reasoning of the Hearing Committee in drawing such inferences. The party requesting the information or documents shall be given the opportunity to state to the Hearing Committee what he or she believes the information or documents would have shown, if it had been provided as directed by the Presiding Officer. Such statement,

If any, shall be made in writing and included as part of the record. Additionally, if the information or documents requested and directed by the Presiding Officer to be provided are accessible by alternative means, the Presiding Officer may in their discretion direct that the party refusing to provide such information or documents pay the cost of obtaining the information by such alternative means.

4.11 ORAL ARGUMENT:

At the conclusion of the evidence, the Hearing Committee may in its discretion request oral argument on any or all of the issues presented by any of the participants to the Fair Hearing Plan. Such oral argument may be requested in addition to any written argument which may also be requested pursuant to the next subsection. The Hearing Committee shall determine whether oral argument is desired, and shall advise the Presiding Officer to issue any request for such oral argument: The time allowed for oral argument shall be set in the discretion of the Presiding Officer, after consultation with the Hearing Committee.

4.12 WRITTEN ARGUMENT:

The Presiding Officer may require the participants to a hearing conducted pursuant to the Fair Hearing Plan, at or prior to the close of the hearing, to submit a written statement concerning any issue, procedure, or alleged fact, and such written statements shall become a part of the hearing record. The Hearing Committee may request written argument on any of the issues placed before the Hearing Committee by the participants to the Fair Hearing Plan. The Presiding Officer shall issue the

request for such written argument at the direction of a majority of the members of the Hearing Committee. The Presiding Officer may place restrictions on the form and length of the written argument presented, after consultation with the Hearing Committee.

4.13 RECORD OF HEARING:

A record of the hearing shall be kept with sufficient accuracy to permit the making of an informed and valid judgment by anybody that may be later called upon to review the record and render a recommendation or decision in the matter.

The method of preserving the record may be by detailed transcription, minutes of the proceedings, electronic recording unit, or court reporter. The Hearing Committee shall select the method to be used. The record of hearing, including the notice, response, all exhibits, tape recordings, findings, and other documents and recordings required to be made a part of the record, shall be kept in a place designated by the Presiding Officer of the Hearing Committee, and shall be made accessible to the participants to the Fair Hearing Plan and the Hearing Committee upon request; provided, however, that the record shall not be permitted to be removed from the place in which the Presiding Officer designates it is to be maintained, without the Presiding Officer's written permission, and provided further that the President may designate that an employee of the Hospital shall be present at all times where any participant to the proceeding is given access to the record. Any participant to a hearing conducted pursuant to the Fair Hearing Plan shall be entitled to a copy of the record upon request and payment of the reasonable expenses incurred in the preparation thereof.

4.14 PRESENCE OF HEARING COMMITTEE MEMBERS AND VOTE:

A majority of the Hearing Committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of the proceedings, they may not participate in the deliberations or the decision.

4.15 RECESS AND RECONVENTION OF HEARING: DELIBERATIONS

The Hearing Committee may, without Special Notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of allowing the participants to obtain new or additional evidence or consultation, subject to the limitations set forth in Section 4.6 above. Upon conclusion of the presentation of oral and written evidence, the hearing shall be concluded and the record shall be closed. The Hearing Committee shall then conduct its deliberations outside the presence of the applicant or Medical Staff Member for whom the hearing was held. New or additional matters or evidence not raised or presented during the hearing shall be introduced during the appellate review process

only in accordance with Section 2.5 herein.

4.16 AGREED DISPOSITION OF PROCEEDINGS:
At any time in the course of the proceedings, the parties to the proceedings may agree that the applicant or Medical Staff Member shall irrevocably withdraw the request for hearing and that the Professional Review Body shall make an adverse recommendation or take an adverse action, or withdraw or modify the proposal for adverse recommendation or action, as agreed by the parties, or make such other agreement as to the proceedings as they deem advisable. The parties may agree pursuant to this Section to any adverse recommendation or action, and are not restricted to the adverse recommendation or action originally proposed by the Professional Review Body. Any agreement for adverse recommendation or adverse action shall be signed by the members of the Professional Review Body and the written consent of the applicant or Medical Staff Member shall be subscribed thereon. Any such agreement shall be subject to approval by the applicable Hearing Committee (to the extent such Hearing Committee had made a recommendation on such matter) and to approval by the Board.

ARTICLE V: HEARING COMMITTEE REPORT AND FURTHER ACTION

5.1 HEARING COMMITTEE REPORT:
Within twenty (20) days following the conclusion of the hearing, the Hearing Committee shall submit a written report to the Board and shall send a copy of such report to each party to the hearing and to the officers of the Medical Staff. Such report shall contain a statement detailing the findings, conclusions and recommendations, including the basis for such recommendations, of the Hearing Committee. Agreement by a majority of all the members of the Hearing Committee shall be required for the issuance by the Hearing Committee of any finding, conclusion, recommendations, basis of recommendations, or report under this Section 5.1. The Hearing Committee may accept, reject or accept with modification the proposed recommendations of the Professional Review Body. The findings, conclusions, recommendations, basis of recommendations and report of the Hearing Committee shall be in such form as the Hearing Committee desires. The Hearing Committee's report shall become a part of the hearing record. Such findings, conclusions, recommendations, basis of recommendations and report shall be based exclusively on the evidence and the matters officially noticed by the Hearing Committee. Such findings, conclusions, recommendations, basis of recommendations and report shall also comply with the requirements of Section 4.9, regarding adverse inferences from the failure to provide information or documents directed to be provided by the Presiding Officer in accordance with that Section.

5.2 ACTION ON HEARING COMMITTEE REPORT:

Within fifteen (15) days after receipt of the written report of the Hearing Committee, any party to the hearing may submit a written statement outlining the findings, conclusions and recommendations of the Hearing Committee with which he or she disagrees and any procedural matters to which he or she objects. Written statements in reply may be submitted by the other parties to the hearing within five (5) days thereafter. All written statements shall be submitted to the President with copies to each other party to the hearing. The written statements shall become part of the hearing record and the Chief of Staff shall distribute copies of the written statements to the Board, the officers of the Medical Staff, and the Hearing Committee. Such written statements also shall constitute the sole written statements considered by an Appellate Review Body in the event of appeal.

ARTICLE VI: INITIATION AND PREREQUISITES OF APPELLATE REVIEW

6.1 REQUEST FOR APPELLATE REVIEW:

Any party to an original hearing may request appellate review of the recommendation of the Hearing Committee by an Appellate Review Body. Requests for an appellate review must be made in writing and either delivered personally or sent by certified mail, return receipt requested, to the President within ten (10) days after such party's receipt of the written report of the Hearing Committee.

6.2 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW:

The failure of any party to request an appellate review within the time and in the manner specified shall constitute a waiver of any right to appellate review, but shall not preclude any party to the hearing from requesting that an Appellate Review Body take an action other than that recommended by the Hearing Committee.

6.3 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW:

The President shall immediately deliver a timely request for appellate review to the chairman of the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review which shall not be less than ten (10) days nor more than twenty (20) days after the President received the request; provided, however, that an appellate review for a Medical Staff Member who is under a suspension then in effect shall be held not later than fifteen (15) days after the President received the request. At least ten (10) days prior to the appellate review, the President shall send the Medical Staff Member Special Notice of the time, place and date of the review. The time may be extended by the Appellate Review Body for good cause.

6.4 APPELLATE REVIEW BODY:

The appellate review may be conducted by the Board as a whole or by an Appellate Review Body consisting of at least three (3) members of the Board appointed by the chairman and one member who is an Active Medical Staff physician. If a committee is appointed, one of its members shall be designated as chairman. The Appellate Review Body shall have no members (i) who actively participated in initiating or investigating the underlying matter at issue, or (ii) who had responsibility for making the proposal giving rise to a hearing right under Section 2.1-1, or (iii) who are in direct competition with the applicant or Medical Staff Member for whom the hearing was conducted. A majority of the members of the Appellate Review Body shall be present in person at each meeting or hearing of the Appellate Review Body. Each member of the Appellate Review Body will affirm, either verbally or in writing, upon the commencement of the appellate review proceeding, that he or she has read this Fair Hearing Plan, that he or she has no reason to doubt their qualifications to serve on the Appellate Review Body, that he or she will perform their responsibilities under the Fair Hearing Plan with impartiality, honesty, and diligence, and that he or she will make every effort to reach a result based upon the evidence which gives due regard to both fairness to the applicant or Medical Staff Member and to the welfare and safety of patients of the Hospital.

ARTICLE VII: APPELLATE REVIEW .PROCEDURE AND FINAL ACT

7.1 NATURE OF PROCEEDINGS:

The Appellate Review Body shall review the hearing record, the findings, conclusions and recommendations, basis for recommendations and report of the Hearing Committee, the written statements submitted pursuant to Section 5.1 of this Fair Hearing Plan, and any written comments submitted by the officers of the Medical Staff on the report of the Hearing Committee. The Appellate Review Body

shall have the right, in its sole discretion, to conduct a hearing *de novo,* if the

Appellate Review Body in good faith believes that a *de novo* hearing is warranted to promote the ends of a fair truth-finding process under all the circumstances of the case. The Appellate Review Body shall have broad discretion in making this determination. The Appellate Review Body acting as a unified body may consult with members of the Hearing Committee or the officers of the Medical Staff on any matter or issue raised before the Hearing Committee.

7.2 REVIEW OF PRESIDING OFFICER'S DETERMINATIONS IN ADMITTING OR EXCLUDING EVIDENCE:

The Appellate Review Body shall consider all objections to the Presiding Officer's decisions admitting or excluding evidence, permitting or not permitting

discovery and other matters. However, the Presiding Officer's decisions shall be presumed correct and shall be reviewed only for a clear abuse of discretion. If the Appellate Review Body finds such a clear abuse of discretion, it shall state in its report under Section 7.10 its reasons for such finding.

7.3 PRESIDING OFFICER:
The chairman of the Appellate Review Body is the presiding officer. He or she determines the order of procedure during the review, makes all required rulings, and maintains decorum.

7.4 ORAL STATEMENTS:
The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative 'appearing is required to answer questions put by any member of the review body.

7.5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS:
New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only in the discretion of the review body and, as the review body deems appropriate, only if the party requesting consideration of the matter or evidence shows that it could not have been discovered in time for the initial hearing. The requesting party shall provide, through the President, a written, substantive description of the additional matter or evidence to the Appellate Review
Body and the other party at least three (3) days prior to the scheduled date of the review.

7.6 POWERS:
The Appellate Review Body has all the powers granted to the Hearing Committee, and any additional powers that are reasonably appropriate to or necessary for the discharge of its responsibilities.

7.7 PRESENCE OF MEMBERS AND VOTE:
A majority of the Appellate Review Body must be present throughout the review and deliberations. If a member is absent from any part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.

7.8 RECESSES AND ADJOURNMENTS:
The Appellate Review Body may recess and reconvene the proceedings without additional notice for the convenience of the participants or for the purpose of

obtaining new or additional evidence or consultation. At the conclusion of the oral statements, if allowed, the appellate review shall be closed. The Appellate Review Body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The appellate review shall be adjourned at the conclusion of those deliberations.

7.9 REPORT OF APPELLATE REVIEW BODY:

Within thirty (30) days following receipt of the request for appellate review, the Appellate Review Body shall complete its deliberations and, unless the Appellate Review Body elects to conduct a *de novo* hearing, prepare a written report accepting, rejecting, or accepting with modifications the recommendations of the Hearing Committee, and the basis of the recommendation. Agreement by a majority of all the members of the Appellate Review Body shall be required for the issuance by the Appellate Review Body of any finding, conclusion, determination, or report under this Section 7.10 or Section 7.11. In the event of a *de novo* hearing, the Appellate Review Body shall be governed by the applicable procedural provisions of this Fair Hearing Plan that would govern the Hearing Committee.

7.10 TIMES ALTERED UPON HEARING DE NOVO:

If the Appellate Review Body elects to conduct a hearing *de novo,* the hearing shall be commenced within thirty (30) days following the determination to conduct such hearing, and the written report of the Appellate Review Body shall be completed within twenty (20) days following the conclusion of the hearing. Upon a *de novo* hearing the Appellate Review Body may in its report accept, reject, or accept with modifications the findings, conclusions, and recommendations of the Hearing Committee. As to any portions of the findings, conclusions, or recommendations of the Hearing Committee rejected by the Appellate Review Body, the Appellate Review Body shall in its report make its own findings, conclusions and/or determinations.

7.11 STATUS OF REPORT OF APPELLATE REVIEW BODY TO PARTIES AND TO HEARING COMMITTEE MEMBERS:

An Appellate Review Body appointed pursuant to Section 6.4 shall have the power to render a final decision on behalf of the Board in connection with the matter giving rise to the hearing. In the event the Appellate Review Body determines to act otherwise than in accordance with the recommendation of the Hearing Committee, the matter shall be submitted to the Joint Conference Committee for further study and recommendation prior to any final decision. The Joint Conference Committee shall be composed of a total of six (6) members selected in the following manner: Three (3) Board members appointed by the Chairman of the Board who are not on the Medical Staff and three (3) Medical Staff members who are not on the

Board appointed by the Chief of Staff. The Joint Conference Committee shall submit its report to the Appellate Review Body within thirty (30) days after the matter is referred, and the Appellate Review Body shall then render its final decision. A copy of any report of the Appellate Review Body shall be provided to each party to the original hearing and to the members of the Hearing Committee.

7.12 ACTION BY APPELLATE REVIEW BODY - NO APPELLATE REVIEW:
If no party to the original hearing requests an appellate review of the recommendations of the Hearing Committee, an Appellate Review Body shall vote to accept, reject, or accept with modifications the recommendations of the Hearing Committee within sixty (60) days following receipt of the written report of the Hearing Committee. Prior to rendering its final decision, the Appellate Review Body shall consider any written comments submitted on the report of the Hearing Committee.

7.13 JOINT CONFERENCE REVIEW:
If the Appellate Review Body determines to act otherwise than in accordance with the recommendations of the Hearing Committee, the matter shall be submitted to the Joint Conference Committee for further study and recommendation prior to any final decision. The Joint Conference Committee shall deliver its report to the Appellate Review Body within thirty (30) days after the matter is referred, and the Appellate Review Body shall then render its final decision. The written decision of the Appellate Review Body, including the basis for its decision, shall be sent by the President, to all parties to the original hearing and to the members of the Hearing Committee. The decision of the Appellate Review Body shall be final and unreviewable.

ARTICLE VIII: GENERAL PROVISIONS

8.1 NUMBER OF HEARINGS AND REVIEWS:
Notwithstanding any other provision of the Bylaws or of this plan, no applicant, or Medical Staff Member is entitled as a right to request more than one evidentiary hearing and appellate review with respect to the subject matter that is the basis of the adverse recommendation or action for which there is a hearing right. Further, no applicant or Medical Staff Member shall have a right to a *de novo* hearing by the Appellate Review Body. Such a hearing shall be limited to cases where the Appellate Review Body determines in good faith that a *de novo* hearing is warranted to promote the ends of a fair truth-finding process under all the circumstances of the case. Adverse recommendations or actions on more than one matter may be consolidated and considered together or separately as the Board shall designate in its sole discretion, and no Professional Review Body shall be precluded from

considering any other proceeding, or evidence therefrom, with respect to a particular applicant, or Medical Staff Member unless the Presiding Officer excludes such evidence for just cause.

8.2 RELEASE:
By requesting a hearing or appellate review under this Fair Hearing Plan, an applicant or Medical Staff Member agrees to be bound by the provisions of Article XII of the Bylaws relating to immunities, releases from liability and confidentiality.

8.3 CONSTRUCTION:
This Fair Hearing Plan shall be interpreted so as to give full force and effect to any pertinent provisions of the Bylaws not set forth herein, except that in the case of any direct conflict between the provisions of the Bylaws and this Fair Hearing Plan, the provisions of this Fair Hearing Plan shall control. Further, this Fair Hearing Plan shall be implemented and interpreted so as to meet the adequate notice and hearing requirements of Section 411(a)(3) of the Act.

8.4 DISTRIBUTION:
A copy of this Fair Hearing Plan shall be delivered to all Medical Staff Members at the time of its adoption, and a copy of each amendment hereto shall be delivered to all Medical Staff Members promptly upon its approval by the Board. A copy of this Fair Hearing Plan, as amended and in effect, also shall be delivered to each applicant who requests an application for appointment to the Medical Staff. A copy of this Fair Hearing Plan shall also be provided with the notice required by Section 3.1, as provided therein. Copies of this Fair Hearing Plan and all amendments hereto shall be maintained in the Administrative Offices of the Hospital.

8.5 PRIVILEGES AND IMMUNITIES:
The Board and any committees of the Medical Staff and/or of the Board which conduct Peer Review Processes, hereby constitute themselves as Professional Review Bodies as defined in the Act and in the Oklahoma Act. Each Professional Review Body hereby claims all privileges and immunities afforded to it by said state and federal statutes. Any action taken by a Professional Review Body pursuant to the Bylaws or this Fair Hearing Plan shall be in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the Hospital) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any applicant or Medical Staff Member, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

8.6 EFFECT OF HEADINGS AND TABLE OF CONTENTS:
The Article and Section headings herein and the Table of Contents are for convenience only and shalt not affect the construction hereof.

8.7 SEVERABILITY CLAUSE:
In case any provision in this Fair Hearing Plan shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

8.8 GOVERNING LAW:
This Fair Hearing Plan shall be governed by, and construed in accordance with the Act and, to the extent not inconsistent therewith, the Oklahoma Act, and to the extent not so governed, with the other laws of the State of Oklahoma without giving effect to its conflict of laws principles.

8.9 COUNTING OF DAYS:
In any instance in which the counting of days is required in this Fair Hearing Plan, the Bylaws or the Rules and Regulations in connection with the giving of notice or for any other purpose, the day of the event shall not count, but the day upon which the notice is given shall count. In any case where the date on which some action is to be taken, notice given or period expired occurs on a holiday, a Saturday or a Sunday, such action shall be taken, such notice given or such period extended to the next succeeding Monday, Tuesday, Wednesday, Thursday or Friday, which is not a holiday. For the purposes of this section, the term "holiday" shall mean such days as are commonly recognized as holidays by the City of Duncan, Oklahoma.

8.10 NOTICES:
All notices, requests, demands, reports, written statements and other communications required or permitted to be given to any applicant or Medical Staff Member in the Bylaws or this Fair Hearing Plan shall be deemed to have been duly given, if in writing and delivered personally or deposited in the United States certified or registered mail, postpaid, return receipt requested, to the address of the applicant or Medical Staff Member on their application or to their last known address according to the books and records of the Hospital.

8.11 CONFIDENTIALITY AND REPORTING:
Actions taken and recommendations made pursuant to the Bylaws or the Fair Hearing Plan shall, to the maximum extent permitted by the Peer Review Statute and other applicable laws, be treated as confidential in accordance

with such policies regarding confidentiality as may be adopted by the Board. In addition, reports of actions taken pursuant to the Bylaws shall be made by the President to such governmental agencies as may be required by law.

8.12 CROSS REFERENCES:

Throughout the document, cross references are made to other sections of this document and to other related documents, such as the Bylaws. By reason of amendments, it is possible that cross references may not always be appropriately changed to conform to the intentions expressed in this or related documents. In such circumstances, such cross references shall be interpreted as applying (i) to the section or subsection designated at the time originally drafted, if such section or subsection is still included in the appropriate document, even though it may have been renumbered or amended, or (ii) to the section or subsection replacing such cross referenced section or subsection, if the content of such replacement section or subsection is such as to be consistent with the original sense of the cross reference.

8.13 COMMENCEMENT AND TERMINATION OF A PEER REVIEW PROCESS:

A Peer Review Process is deemed to commence (i) with respect to a potential corrective action, upon receipt of the first complaint or expression of the first concern regarding any applicant or Medical Staff Appointee; (ii) with respect to a Credentialing Process, upon the first contact by the Hospital with such applicant or proposed applicant; and (iii) for other Peer Review Processes, as specified by the applicable Hospital Representatives. The quality assurance and other on-going quality of care monitoring by the Hospital of Medical Staff appointees shall constitute continuous Peer Review Processes. A Peer Review Process will be deemed to have terminated (i) as to a proposed corrective action, when the concerns regarding the particular applicant or Medical Staff Appointee have been resolved or a final determination has been made respecting such applicant or Medical Staff Appointee;(ii) as to a Credentialing Process,' upon a final determination by the Board regarding the application for appointment and/or reappointment; and (iii) for other Peer Review Processes, as specified by the applicable Hospital Representatives. The commencement and termination of particular Peer Review Processes shall be documented in a manner designed to achieve maximum protection for Peer Review Information under the Peer Review Statute.

8.14. PEER REVIEW INFORMATION:

All Peer Review Information and any other documents utilized during a Peer Review Process shall be maintained in accordance with the Hospital's record retention policy pertaining to such information.

ARTICLE IX: AMENDMENT

9.1 AMENDMENT:

9.1-1 AT INITIATION OF MEDICAL STAFF:

The Medical Staff may, at any regular or special meeting, recommend to the Board that amendment{s) be made in this Fair Hearing Plan, provided that a copy of any proposed amendment{s) shall be distributed or made available to each member of the Medical Staff at least thirty {30) days in advance of such meeting. The Board shall consider such recommendations within sixty {60) days. If the Board is in disagreement with the recommendations of the Medical staff, the matter shall be referred for joint conference pursuant to Section 7.14 for further study and recommendation before final action is taken by the Board.

9.1-2 AT INITIATION OF BOARD:

The Board may propose amendments to this Fair Hearing Plan at any time. A copy of any proposed amendment{s) to this Fair Hearing Plan shall be distributed to each member of the MEC at least thirty {30) days in advance of the meeting at which the Board proposes to take final action thereon. If a majority of the members of the MEC are in disagreement with the proposed amendment{s), the matter shall be referred for joint conference for further study and recommendation before final action is taken by the Board. Notwithstanding the foregoing, the Board may amend this Fair Hearing Plan without prior notification to the MEC if immediate action is necessary in order to comply with any federal, state or local law or regulation or to enable the Hospital or the Medical Staff to avoid potential liability.

9.1-3 EFFECTIVE DATE:

Any amendments to this Fair Hearing Plan shall become effective when adopted by the Board.

9.2 RESPONSIBILITIES AND AUTHORITY:

The procedures outlined in the Medical Staff and Hospital Bylaws regarding Medical Staff responsibility and authority to formulate, adopt and recommend Bylaws and amendments thereto and the circumstances under which the Board may resort to its own initiative in accomplishing those functions apply as well to the formulation, adoption and amendment of this Fair Hearing Plan.