IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, et al.	)	
Plaintiffs,	)	
v.	)	Case No. 2:16-cv-04313-HFS
PETER LYSKOWSKI, in his official capacity as Director of the Missouri Department of Health and Senior Services, et al.	)	
Defendants.	)	

PLAINTIFFS' SUGGESTIONS IN OPPOSITION TO STATE DEFENDANTS' MOTION TO DISMISS

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Because they have no persuasive answer to the fact that the Supreme Court's recent decision in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) [*hereinafter Whole Woman's Health* or *"WWH"*], renders unconstitutional Missouri's requirements that facilities that provide abortion must be licensed as ambulatory surgical centers[1] ("ASC Restriction") and physicians who provide abortion must have local hospital privileges and/or a transfer agreement with a local hospital[2] ("Hospital Relationship Restriction") (together, the "Restrictions"), Defendants Lyskowski and Hawley (collectively, the "State Defendants") seek to create threshold roadblocks by contending that (1) none of Plaintiffs' claims are ripe for review; (2) Plaintiffs' challenge to the Hospital Relationship Restriction and Comprehensive Health's challenge to the ASC Restriction are not redressable, and (3) Comprehensive Health's challenge to the ASC Restriction is prohibited by a prior settlement agreement. These arguments are meritless and should be rejected.

ARGUMENT

I. Plaintiffs' Claims are Ripe for Review

The State Defendants advance several arguments that Plaintiffs' claims are not ripe for review, but each of these arguments fails. A case is ripe when (1) the issues are fit for review; and (2) the Plaintiffs would suffer significant hardship if the court were to withhold consideration. *Abbott Laboratories v. Gardner*, 387 U.S. 136, 149 (1967).

A. Plaintiffs' Challenge to the ASC Restriction is Fit for Review

First, the State Defendants argue that Plaintiffs' challenge to the ASC Restriction is not fit for review because Plaintiffs have not sought, and been denied, waivers from the Department

[1] Mo. Ann. Stat. § 197.200.
[2] Mo. Ann. Stat. § 197.215, Mo. Code Regs. Ann. tit. 19, § 30-30.060(1)(C)(4), Mo. Ann. Stat. § 188.080, and Mo. Ann. Stat. § 188.027(1)(1)(e).

of Health and Senior Services ("DHSS") of the ASC Restriction's regulations with which they cannot comply. Suggestions in Supp. of Defs.' Mot. to Dismiss for Lack of Jurisdiction, ECF No. 27, at 8 ("Defs.' Br.").

As an initial matter, there can be no dispute that Plaintiffs' equal protection challenge to the ASC Restriction is ripe whether or not Plaintiffs seek waivers. The equal protection injury is the imposition of more onerous requirements for facilities that provide abortion as opposed to other procedures, and that injury exists regardless of the availability of waivers of some of the ASC requirements. *Northeastern Fla. Chapter, Associated Gen. Contractors of America v. Jacksonville*, 508 U.S. 656, 666 (1993) ("When the government erects a barrier that makes it more difficult for members of one group to obtain a benefit than it is for members of another group . . . [t]he 'injury in fact'. . . is the denial of equal treatment resulting from the imposition of the barrier. . .'"); *see also Meadows of West Memphis v. City of West Memphis, Ark.*, 800 F.2d 212, 215 (8th Cir.1986) (finding equal protection claim ripe where plaintiff alleged City blocked its access to public financing for at least a year because the delay itself was the injury).

Plaintiffs' substantive due process challenge to the ASC Restriction is also ripe. The State Defendants' argument that Plaintiffs must attempt to comply individually with each of the ASC Restriction's implementing regulations is contrary to the Supreme Court's clear holding in *Whole Women's Health* that, when an ASC Restriction is unconstitutional on its face, a court is not required to "proceed in piecemeal fashion" and "invalidate . . . only those specific surgical-center regulations that unduly burden the provision of abortions, while leaving in place other surgical-center regulations." *WWH*, 136 S. Ct. at 2319. Plaintiffs have brought a facial challenge to the statute that requires abortion facilities to be licensed as ASCs, Complaint, ECF No. 1 at 18, and they are therefore not required to show on an individual basis that they cannot obtain a waiver

for each and every one of the statute's implementing regulations.

Furthermore, the law is clear that a plaintiff is not required to seek an administrative waiver where it would be futile to do so. *See, e.g., South Dakota Mining Ass'n, Inc. v. Lawrence County*, 155 F.3d 1005, 1008–09 (8th Cir. 1998). And applying for waivers would most certainly be futile. While certain of the ASC Restriction's physical facility requirements may be waived, Mo. Code Regs. Ann. tit. 19, § 30-30.070(1), other requirements may not be, including the requirement that physicians have hospital privileges. *See* Mo. Code Regs. Ann. tit. 19, § 30-30.060 (listing various requirements not subject to a waiver procedure); *see also* Letters from John Langston to Vicki Casey, Nov. 2, 2016, attached as Ex. B to Decl. of Laura McQuade in Supp. of Pls.' Mot. for Prelim. Inj., ECF No. 15-1 ("McQuade Decl.") (stating that an abortion facility is not eligible for a license until its physicians comply with the criminal privileges law). Thus, even if Plaintiffs obtained waivers of some physical facility requirements, as long as Plaintiffs cannot meet the privileges requirement,[3] they will be unable to obtain ASC licenses. Therefore, seeking waivers would be an exercise in futility, and Plaintiffs are not required to go through such an exercise. *South Dakota Mining Association*, 155 F.3d at 1008-09 ("Because applying for and being denied a . . . permit . . .would be an exercise in futility, we will not require plaintiffs to do so before they may challenge the ordinance); *see also Ward v. County of Orange*, 217 F.3d 1350, 1356 (11th Cir. 2000) ("[A] party need not seek a binding conclusive . . . decision where such an effort would be futile."); *Sammon v. N.J. Bd. of Med. Examiners*, 66 F.3d 639, 643 (3d Cir. 1995) (same).

[3] Comprehensive Health's physicians Drs. Moore and Yeomans applied for privileges at Menorah Medical Center that would fulfill the privileges requirement of the 2010 settlement agreement for the Kansas City health center, and indeed, they recently learned that they had obtained privileges, though Defendant DHSS has refused to confirm that those privileges are sufficient for licensure. Supplemental Decl. of Laura McQuade ¶ 3 ("McQuade Suppl. Decl."), attached hereto as Ex. 1.

In addition, the suggestion that DHSS has given out waivers freely, Def.s' Br. at 12 n. 2, could not be further from the truth. When Planned Parenthood sought waivers of the ASC requirements for the Kansas City and Columbia health centers in 2007, DHSS refused to even respond to their correspondence. *Planned Parenthood of Kansas v. Drummond*, No. 07-4164-cv-C-ODS, 2007 WL 2811407, at *2 (W.D. Mo. Sept. 24, 2007). Only after Planned Parenthood sued DHSS and won a preliminary injunction did DHSS "waive" certain requirements as part of a settlement agreement. McQuade Decl. ¶ 14.[4] The State Defendants also ignore the fact that, while Plaintiffs did not utilize a formal process to seek waivers of the ASC requirements, following the Supreme Court's decision in *Whole Women's Health*, Plaintiff Comprehensive Health, through its attorneys, corresponded with DHSS regarding its position on the enforceability of the ASC Restriction and that correspondence confirmed that without hospital privileges, DHSS would not license the health centers. McQuade Decl. Exs. A–D.

The cases cited by the State Defendants are not to the contrary, and, in fact, support Plaintiffs. For example, Defendants cite *Suitum v. Tahoe Regional Planning Agency*, 520 U.S. 725, 738–39 (1997), for the point that a landowner must seek a variance to ripen its claim. Critically, however, they omit that the Court held the landowner's claims were ripe because the land-use agency had no discretion to grant her a variance. *Id.* at 739. This is analogous to the instant case, where DHSS may not waive certain ASC requirements that Plaintiffs cannot meet, and therefore has no discretion to grant Plaintiffs licenses. Defendants' other citations are inapplicable, as each involves an administrative action in which the result was entirely speculative, unlike the present case, where, even if DHSS might grant some limited waivers, it is

[4] Furthermore, as is explained in detail below, since the entry of the settlement agreement DHSS has attempted at every turn to prevent these facilities from being licensed, by shifting its interpretation of what is required under the agreement and by attempting to illegally revoke the Columbia facility's most recent license in 2015. *See infra* § III.

certain that those waivers will not result in Plaintiffs' health centers being licensed.[5] For all of these reasons, Plaintiffs are unable to obtain ASC licenses, and their injury is fit for review.

B. Plaintiffs' Challenge to the Hospital Relationship Restriction is Fit for Review

The State Defendants next argue that Plaintiffs' challenge to the Hospital Relationship Restriction is not fit for review because, they say, it is "undetermined" whether Plaintiffs' physicians can obtain hospital privileges because the physicians have not applied for privileges at each qualifying hospital and been denied. Defs.' Br. 16–19. First, as with Plaintiffs' equal protection challenge to the ASC Restriction, their equal protection challenge to the Hospital Relationship Restriction is plainly ripe regardless of whether Plaintiffs' physicians apply for privileges at each qualifying hospital. The equal protection injury is the fact that Missouri imposes more onerous requirements on physicians who provide abortion than on other physicians, and that injury exists regardless of whether Plaintiffs' physicians apply for privileges. *Associated Gen. Contractors*, 508 U.S. at 666; *Meadows*, 800 F.2d at 215.

Furthermore, despite the fact that court after court, including the U.S. Supreme Court, has held that physicians who provide abortion have little chance of obtaining privileges to comply with similar laws, *Whole Woman's Health*, 136 S. Ct. at 2312 (explaining that physicians who provide abortion cannot obtain hospital privileges for reasons unrelated to clinical competence);

[5] *See McCarthy v. Ozark Sch. Dist.*, 359 F.3d 1029, 1037 (8th Cir. 2004) (holding challenge to administrative exemption process that broadened immunization exemption for schoolchildren unripe because schoolchildren had not applied or been denied an exemption under the new law and regulations); *Felmeister v. Office of Attorney Ethics*, 856 F.2d 529, 537–38 (3d Cir. 1988) (holding claim against attorney advertising rules unripe because plaintiffs had not submitting proposed advertisement to committee to determine whether advertisements violated the rule); *Missouri ex rel. Missouri Highway & Transp. Comm'n v. Cuffley*, 112 F.3d 1332, 1337–38 (8th Cir. 1997) (holding State's declaratory-judgment action against KKK unripe because "State never acted on the Klan's application [to participate in Adopt-A-Highway program], choosing instead to seek advance court approval of its plans to deny the application" and "[[b]ecause we cannot determine what reasons the State actually will choose to support its denial").

Planned Parenthood of Wisconsin, Inc. v. Schimel, 806 F.3d 908, 916-17 (7th Cir. 2015), *cert. denied*, 136 S. Ct. 2545, 195 L. Ed. 2d 869 (2016) (same); *Planned Parenthood Se., Inc, et al. v. Strange*, 33 F. Supp. 3d 1330, 1347 (M.D. Ala.), *as corrected* (Oct. 24, 2014), *supplemented*, 33 F. Supp. 3d 1381 (M.D. Ala. 2014), and *amended*, No. 2:13-cv-405-MHT, 2014 WL 5426891 (M.D. Ala. Oct. 24, 2014) (same); *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 450 (5th Cir. 2014) (same), Plaintiffs diligently reached out to each and every qualifying hospital near each of the health centers to inquire about their requirements for privileges. The uncontradicted evidence here supports the findings of those courts and shows that Plaintiffs' physicians cannot comply with the Restriction;[6] Plaintiffs' physicians are categorically disqualified from obtaining privileges at many of the relevant hospitals for various reasons unrelated to the physicians' capacity to provide abortion care, including, among other things, local residency requirements, hospitals' religious affiliations, and not having required faculty appointments. McQuade Decl. ¶¶ 19–25, 32; Supplemental Decl. of Laura McQuade ¶¶ 9–13 ("McQuade Suppl. Decl."); Decl. of David Eisenberg in Supp. of Pls.' Mot. for Prelim. Inj., ECF No. 15-3, ¶¶ 55–58 ("Eisenberg Decl."); Rebuttal Decl. of David Eisenberg in Supp. of Pls.' Mot. for Prelim. Inj., ECF No. 42-1 ¶¶30–32. The remaining hospitals have either explicitly refused to work with Planned Parenthood physicians, or have refused to even return email and phone inquiries seeking information regarding the privileging process. McQuade Decl. ¶¶ 29–31, 33; McQuade Suppl. Decl. ¶¶ 9–13.

[6] Defendants point out that Drs. Moore and Yeomans applied for privileges at Menorah Medical Center, in Overland Park, Kansas. The physicians did so because Comprehensive Health's physicians have historically had a positive relationship with Menorah, and Dr. Moore has held various forms of privileges over the years. McQuade Suppl. Decl ¶ 2. Furthermore, the physicians reside in Kansas City, and so are able to meet the hospital's requirements for privileges. *Id*. The evidence is uncontradicted that none of the hospitals in the other cities in Missouri outside of St. Louis would provide the required privileges.

Defendants suggest that Plaintiffs' physicians might be able to convince hospitals to waive their requirements, but this is purely speculative. Other courts considering privilege requirements have held that physicians are not required to apply to hospitals based on the speculative possibility that a hospital would bend its requirements to accommodate them. *Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 987 (W.D. Wis. 2015), *aff'd sub nom. Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015), *cert. denied*, 136 S. Ct. 2545, 195 L. Ed. 2d 869 (2016) ("While perhaps an individual physician might pull strings or persuade a hospital to ignore standard credentialing requirements, . . .[t]he preponderance of the evidence is that hospitals are generally unwilling to bend their rules, even for physicians that they know . . ."); *Strange*, 33 F. Supp. 3d at 1347 ("Evidence of mere possibility and speculation [that hospitals would waive requirements] is insufficient to rebut the consistent evidence that the abortion clinics' doctors are ineligible for privileges. . .").

It is therefore abundantly apparent that Plaintiffs' physicians cannot get privileges at any hospital that would satisfy the requirements of the Hospital Relationship Restriction, and that going through the process of applying for them, and being denied, would only be an exercise in hoop-jumping. Not only is such an exercise not legally required, but the physicians' careers could be seriously harmed by requiring them to apply for privileges when they are sure to be denied, as such denials are reportable on future privilege applications and can prevent physicians from obtaining future employment. Eisenberg Rebuttal Decl. ¶ 18; *see also Strange*, 33 F. Supp. 3d at 1347 (finding that submitting futile applications for hospital privileges can damage physicians' professional reputations and future employment opportunities).

Again, the law is clear that plaintiffs are not required to go through this sort of futile (and potentially damaging) exercise in order to ripen their claims. *South Dakota Mining Association*,

155 F.3d at 1008-09. Indeed, when faced with identical claims, other courts did not find a ripeness problem; they adjudicated plaintiffs' substantive due process challenges, finding that a requirement that physicians who perform abortions have local hospital admitting privileges is unconstitutional. *See Van Hollen*, 94 F. Supp. 3d at 987 (finding "credible" abortion providers' "assessment that the chances of securing admitting privileges at a Milwaukee hospital are 'slim to none,'" where physicians submitted applications only at hospitals where they believed they had the best chance of securing privileges); *Strange*, 33 F. Supp. 3d at 1343 (finding, based on testimony from abortion providers and language in hospital bylaws that "none of the current [] doctors at the plaintiffs' clinics would be able to obtain . . . privileges, even if they applied").

C. Plaintiffs and their Patients Would Suffer Significant Hardship If the Court Withheld Consideration of Their Claims

Plaintiffs also fulfill the second ripeness prong, that they will suffer significant hardship if the Court were to withhold consideration of their claims. *Abbott Laboratories*, 387 U.S. at 149. The State Defendants argue that the only hardships in this case are financial and the hardship of having to go through an administrative proceeding, Defs.' Br. at 11-12, but Defendants ignore that Plaintiffs' patients, on whose behalf they bring this litigation, Compl. ¶ 8-9, are being irreparably harmed on an ongoing basis by the Restrictions, and any additional delay compounds this harm. Plaintiffs have made a robust showing that the restrictions force Missouri women to travel long distances to obtain an abortion, increasing the cost and logistical difficulty of obtaining care, and that this prevents some women from obtaining an abortion and delays others, increasing the risk to their health. *See* Suggestions in Supp. of Pls.' Mot. for Prelim. Inj., ECF No 15, at 14–16; s*ee also, e.g., Drummond*, 2007 WL 2463208, at *3 (Plaintiff's showing that Missouri's ASC Restriction will force two health centers to cease providing abortion and therefore "will interfere with the exercise of its constitutional rights and the rights of its patients

constitutes irreparable harm") (internal quotations omitted); *Roe v. Crawford*, 396 F. Supp. 2d 1041, 1043-44 (W.D. Mo. 2005) (finding that delay in obtaining abortion procedure "may cause [patient] substantial injury, exposing her to increased medical, financial, and psychological risks"). Furthermore, Plaintiffs are suffering ongoing harm because the Restrictions are preventing them from fulfilling their mission of providing comprehensive reproductive health care to Missouri women and pursuing their businesses and professions. McQuade Decl. ¶ 50; Decl. of Mary Kogut in Supp. of Pls.' Mot. for Prelim. Inj., ECF No. 15-2, ¶ 19.

Defendants are also incorrect that any hardship to Plaintiffs is their own fault because they have delayed filing this litigation following the Supreme Court's decision in *Whole Women's Health*. Defs.' Br. at 12. On the contrary, courts have made clear that it is entirely proper for litigants to engage in good faith investigation and negotiation prior to filing a lawsuit. *See, e.g.*, *Safety-Kleen Sys., Inc. v. Hennekins*, 301 F.3d 931, 936 (8th Cir. 2002) (affirming district court finding that seven months was not an unreasonable amount of time for plaintiff to "marshal its case for a preliminary injunction . . . ."); *Monarch Prods., LLC v. Zephyr Grafix, Inc.*, No. 4:09-cv-02049-ERW, 2010 WL 1837711, at *6 (E.D. Mo. May 4, 2010), *order vacated in part on reconsideration on other grounds*, 2010 WL 2348625 (E.D. Mo. June 9, 2010) ("Spending several months completing due diligence and preparing for filing the pending lawsuit is a reasonable use of time. The Court certainly does not want to discourage potential plaintiffs from engaging in a good faith investigation or meaningful negotiation before filing a lawsuit or seeking a preliminary injunction.").

Here, prior to filing this action, Plaintiffs spent several months corresponding with DHSS about the impact of *Whole Woman's Health* on the laws at issue in this case in an attempt to avoid litigation. McQuade Decl. Exs. A–D. This back and forth included a license application for

the Kansas City facility, inspections of both the Kansas City and Columbia facilities, and follow up correspondence after the inspections. *Id*. Indeed, the last communication between DHSS and Plaintiffs' attorneys is dated November 18, 2016, less than two weeks before this lawsuit was filed. *Id*. Ex. D. Defendants suggest that Plaintiffs should have instead filed waiver applications and that doing so would have sped up resolution of this case, but, as has already been explained above, *supra* § I.A., because the ASC Restriction's implementing regulations contain unwaiveable requirements that Plaintiffs cannot meet, engaging in the waiver process would have been futile and only prolonged the filing of this case.

Plaintiffs also made extensive efforts to comply with the Hospital Relationship Restriction prior to filing this case, including contacting every qualifying hospital near each health center regarding both whether the hospital would enter into a transfer agreement with the health centers and regarding the hospitals' requirements for physician privileges. These pre-filing preparations are entirely proper and certainly do not amount to undue delay.

Plaintiffs satisfy both prongs of the ripeness inquiry as to each claims. Their claims are therefore justiciable.

II. Plaintiffs' Claims are Redressable

The State Defendants argue that, because Plaintiffs' challenge to the ASC Restriction is invalid, Plaintiffs' challenge to the Hospital Relationship Restriction is not redressable. Defs.' Br. at 15–16. However, this argument hinges entirely on the State Defendants' position that Plaintiffs' challenge to the ASC restriction is unripe because Plaintiffs did not seek waivers of certain of the ASC requirements. As has been explained in detail above, however, Plaintiffs' challenge to the ASC restriction is plainly ripe; therefore the State Defendants' redressability argument as to Plaintiffs' challenge to the Hospital Relationship Restriction fails.

The State Defendants also argue that Comprehensive Health's challenge to the ASC Restriction is not redressable because of deficiencies that are "independent of the challenged requirements." Defs.' Br. at 19-20. Specifically, they argue – based on the results of their recent inspections – that Plaintiffs have not presented evidence that they cannot comply with every one of the ASC Restriction's implementing regulations, and therefore the Court should "deem" Plaintiffs to have challenged only those regulations regarding which they have presented such evidence.[7] Defs.' Br. at 20 n. 3. However, Plaintiffs have brought a facial challenge to the statute that requires abortion facilities to be licensed as ASCs, Compl. at 18, and, as explained *supra* at § I.A., they are not required to present evidence as to each and every aspect of the statute's implementing regulations in order to bring such a facial claim. *WWH*, 136 S.Ct. at 2319 (when an ASC Restriction is facially unconstitutional, a court is not required to "proceed in piecemeal fashion" and "invalidate . . . only those specific surgical-center regulations that unduly burden the provision of abortions, while leaving in place other surgical-center regulations"). Therefore, should Plaintiffs be granted the relief they have requested from the requirement that facilities that provide abortion be licensed as ASCs, there will be no redressability problem, as Plaintiffs would not be required to meet any of the ASC Restriction's implementing regulations.

The State Defendants also entirely mischaracterize the nature of the quality assurance and infection control "deficiencies" DHSS identified at Comprehensive Health's health centers, making inflammatory statements such as "the Columbia facility 'did not have a quality assurance program to track post-abortion complications" and "the Kansas City facility currently fails to meet basic standards of infection control." Defs.' Br. at 19-20. These statements could not be

[7] In particular, the State Defendants ask the Court to "deem" Plaintiffs' challenge to only apply to Mo. Code Regs. Ann. tit. 19, §30-30.070, which contains the physical plant requirements of the ASC Restriction, as well as the aspects of the Hospital Relationship Restriction that are contained within the ASC Restriction.

further from the truth. In fact, the "deficiencies" DHSS identified at these facilities largely related to the fact that neither facility currently provides abortions, and necessitated only the sort of minor changes that DHSS commonly requires when it inspects a healthcare facility, such as making slight changes to policies and ordering and/or relocating certain supplies and equipment. McQuade Suppl. Decl. ¶¶ 4–8. Indeed, all of the changes DHSS asked Comprehensive Health to make with regard to quality assurance and infection control have already been made.[8] *Id*. The post-inspection changes DHSS requested, therefore, pose no redressability problem.

III. The 2010 Settlement Agreement Does Not Bar Comprehensive Health's Challenge to the ASC Restriction

The State Defendants wrongly contend that the 2010 Settlement Agreement ("Settlement") that resolved a prior lawsuit regarding the ASC Restriction bars Comprehensive Health's challenge to the ASC Restriction here.[9] As an initial matter, this argument overlooks

[8] While the State Defendants only mention the above deficiencies in their brief, the remaining items raised by DHSS in its post-inspection letters (for example, requesting other minor policy changes and requesting that a bathroom exhaust system be modified, McQuade Decl. Ex. B), are all similarly straightforward to address. However, as Plaintiffs explained to DHSS in correspondence prior to filing this litigation, because Comprehensive Health's physicians do not currently have hospital privileges that meet the requirements of the Hospital Relationship Restriction and/or the Settlement, and DHSS therefore will not grant a license at either facility, it would be a waste of Comprehensive Health's money and staff resources to make the remaining requested changes at this time. McQuade Suppl. Decl. ¶ 8; McQuade Decl. Ex. C.

[9] The State Defendants also claim, without explanation, that all of Plaintiff Comprehensive Health's claims are unripe because it has "refused to comply with the terms of the settlement agreement." Defs.' Br. at 15. As an initial matter, this statement is false. Indeed, both Comprehensive Health's Kansas City and Columbia Health centers have at times been licensed under the settlement agreement, the Columbia health center as recently as 2015, when those health centers were able to comply with the Hospital Privileges Requirement. Aff. of John Langston, ECF No. 27-1, Attachment E. Far from refusing to comply, Comprehensive Health made extensive, costly renovations to the Columbia health center to bring it into compliance with the settlement agreement's requirements, and has jumped through hoops to attempt to comply on an ongoing basis with DHSS's changing interpretations of what the settlement agreement requires. *Id*. Attachment B; McQuade Decl. 16-17. Comprehensive Health furthermore is not currently "refus[ing] to comply" with the agreement—rather, Comprehensive Health's physicians do not have privileges that satisfy the settlement agreement, and it would therefore be

that Comprehensive Health is only one of the plaintiffs in this action to bring a facial challenge to the ASC Restriction—indeed, Defendants do not contend that the Settlement bars the claims of Plaintiff RHS. Furthermore, the prior lawsuit did not involve a challenge to the Hospital Privileges Restriction, so the Settlement does not affect that claim. *See* Am. Compl., *Planned Parenthood of Kan. & Mid-Mo. v. Drummond*, No. 2:07-cv-04164-NKL (W.D. Mo. Sept. 7, 2007) (ECF No. 47) ("*Drummond* Compl.") attached hereto as Ex. 2. Therefore, even if the Court were to find that Comprehensive Health's challenge to the ASC Restriction must be dismissed, this would not affect the contours of this case. *Cf. Sierra Club v. U.S. Army Corps of Engineers*, 645 F.3d 978, 986 (8th Cir. 2011) (only one plaintiff needs to show standing in order to maintain litigation). Because RHS clearly may challenge the ASC Restriction— and is entitled to facial relief that the Restriction is unconstitutional in light of *Whole Woman's Health*—whether Comprehensive Health may bring this claim is a question this Court need not resolve.

In any event, the Settlement does not bar Comprehensive Health's claim because the Settlement's release only bars suits based on the "allegations in the [2007 suit]," and does not bar later actions based on new or different facts.[10] Aff. Of John Langston, ECF No. 27-1,

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futile for Comprehensive Health to expend money and staff resources to make the medically unnecessary changes DHSS is requiring under the settlement agreement or to make the final preparations necessary for their health centers to provide abortions services. McQuade Suppl. Decl. ¶ 8; McQuade Decl. Ex. C. In any event, if the State Defendants are trying to argue that Comprehensive Health's "refusal" to comply with the settlement agreement renders its claims unripe because it must show that it cannot comply with the settlement agreement before it can bring this litigation, Comprehensive Health has done so. *See* McQuade Decl Ex. A–D (noting that DHSS will not issue licenses to the Kansas City and Columbia health centers under the settlement agreement because Comprehensive Health's physicians do not have the required privileges).

[10] In Missouri, in construing a contractual release, the parties' intent governs, which in turn is determined by the language used in the release. *McIntire v. Glad Heart Properties*, 399 S.W.3d 505, 509 (Mo. Ct. App. 2013; *see also State ex rel. Normandy Orthopedics, Inc. v. Crandall*, 581 S.W.2d 829, 833 (Mo. en banc 1979) ("Any question regarding the scope and extent of a release is to be determined according to what may fairly be said to have been within the contemplation

Attachment B ¶ 10 ("Langston Aff.). The 2007 suit involved a pre-enforcement, as-applied challenge to the way in which DHSS was applying the ASC Restriction to the Columbia and Kansas City facilities at the time. *See Drummond* Compl. at 20, ¶¶ 3–6 (seeking declaratory and injunctive relief against the amended ASCLL and regulatory scheme, "as DHSS proposes to apply them"). The present action, on the other hand, is a post-enforcement challenge to the statute that sweeps facilities at which abortion is provided into the definition of ASC, and that is based on facts that arose following the 2007 lawsuit and entry of the 2010 Settlement.

In particular, Plaintiffs seek relief in the present action based in part on the fact that "DHSS has repeatedly changed its position on what it will require under the settlement agreement." Compl. ¶¶ 29, 58–60. Defendant suggests that Plaintiff is attempting to deny DHSS the benefit of its bargain but, in fact, Plaintiff has not received the intended benefit of the Settlement, the purpose of which was to reach terms under which DHSS would license the Kansas City and Columbia facilities—the Settlement itself states that DHSS "will approve the [facilities] for licensure as abortion facilities." Langston Aff. Attachment B ¶ 5. However, DHSS has attempted at every turn to prevent these facilities from being licensed. DHSS has declared that several of Comprehensive Health's policies, the number of recliners in the Columbia facility's recovery area, and the exhaust system in a patient restroom no longer to meet the requirements of the Settlement, even though DHSS has repeatedly approved all these items as recently as 2015. *See* McQuade Decl. ¶ 17. Tellingly, when the Columbia facility most recently held a license, DHSS attempted to immediately terminate it as a result of political pressure, without going through the statutorily required plan of correction process that DHSS normally

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of the parties at the time the release was given, which, in turn, is to be resolved in the light of all the surrounding facts and circumstances under which the parties acted." (internal quotation marks omitted)).

provides to other ASCs. McQuade Decl. ¶ 17; *Planned Parenthood of Kan. and Mid-Mo. Inc. v. Lyskowski*, No. 2:15-CV-04273-NKL, 2016 WL 2745873, at *1 (W.D. Mo. May 11, 2016).

These new, material facts that have arisen since the entry of the Settlement mean that Comprehensive Health's post-enforcement facial challenge to the ASC Restriction is not barred. *Cf. Whole Woman's Health*, 136 S. Ct. at 2305 ("a slight change of circumstances" can provide the basis for finding a second action is not identical to the first "where important human values . . . are at stake.") (quoting Restatement (Second) of Judgments § 24, cmt. f, and citing *Bucklew v. Lombardi*, 783 F.3d 1120, 1127 (8th Cir. 2015), as "allowing as-applied challenge to execution method to proceed notwithstanding prior facial challenge").

CONCLUSION

Therefore, for the foregoing reasons, Plaintiffs respectfully request that the Court deny the State Defendants' Motion to Dismiss.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on January 31, 2017 a copy of the foregoing has been served upon all counsel of record in this action by electronic service through the Court's CM/ECF system.

/s/ Melissa A. Cohen
Melissa A. Cohen

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, et al. Plaintiffs, v. PETER LYSKOWSKI, in his official capacity as Director of the Missouri Department of Health and Senior Services, et al. Defendants.	)	Case No. 2:16-cv-04313-HFS

SUPPLEMENTAL DECLARATION OF LAURA MCQUADE

I, Laura McQuade, declare and state the following:

1. I previously submitted a declaration in this case entitled "Declaration of Laura McQuade in Support of Plaintiffs' Motion for a Preliminary Injunction." I am the President and Chief Executive Officer of Comprehensive Health of Planned Parenthood Great Plains ("Comprehensive Health"). I am responsible for the management of this organization, and, therefore, am familiar with our operations and finances, including the services we provide and the communities we serve. I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction.

Comprehensive Health's Physicians' Privileges

2. Since my initial declaration, Drs. Moore and Yeomans have heard back from Menorah Medical Center ("Menorah") regarding their respective applications for reappointment and for new privileges. Dr. Moore has been reappointed to the Menorah Medical Staff with Affiliate/Associate level privileges, and Dr. Yeomans has been granted Active Staff privileges. As the appropriate level of privileges for Dr. Yeomans is actually Affiliate/Associate privileges,

which is meant for physicians who practice primarily in an office-based specialty and who have no more than 50 patient contacts at the hospital during a given year, Comprehensive Health staff has reached out to Menorah to ask that this level be corrected, and Menorah has assured us that the correction will be made at the hospital's next board meeting. Comprehensive Health's physicians have historically had a positive relationship with Menorah, and Dr. Moore has held various forms of privileges over the years. Drs. Moore and Yeomans are able to meet Menorah's requirements for privileges, including residency near the hospital and various coverage requirements that they are unable to meet at out-of-town hospitals. *See* Menorah Bylaws, Ex. A, *infra*. Menorah also does not require any evaluation of physicians' treatment of patients in the hospital setting. *Id*.

3. On January 13, 2017 and January 17, 2017, Comprehensive Health's attorneys provided this information to the Department of Health and Senior Services ("DHSS" or the "Department") via letters, which included documentation from Menorah regarding the physicians' privileges, and asked DHSS to respond by January 24 regarding whether it considers these privileges to meet the requirements of the 2010 settlement agreement. Letters from Arthur Benson & Melissa Cohen, Attys for Comprehensive Health, to John Langston, Admin., Bureau of Ambulatory Care, Mo. DHSS, (January 13, 17, 2017), attached as Ex. A. To date, DHSS has not responded.

DHSS's November 2016 Inspections of the Kansas City and Columbia Health Centers

4. Following DHSS's November 2016 inspections of the Kansas City and Columbia Health Centers, DHSS issued letters to Comprehensive Health regarding each facility in which it listed changes it would require to Comprehensive Health's policies and/or procedures before DHSS would issue licenses to the facilities. All of the issues raised by the Department required

only minor changes, and many of those issues have already been resolved. It is entirely normal that, as part of a licensing inspection, DHSS representatives ask facilities to make these sorts of changes and, importantly, a number of the "deficiencies" noted by the department were simply a function of the fact that neither facility is currently providing abortion services.

5. DHSS asked Comprehensive Health to make changes at both facilities that fall under the "infection control" umbrella, but the changes DHSS requested were minor. For example, DHSS stated in its letters that neither facility had the supplies on hand for the disinfection of ultrasound probes. Decl. of Laura McQuade in Supp. of Pls.' Mot. for Prelim. Inj., ECF No. 15-1, Ex. B ("McQuade Decl").Ex. B. Importantly, however, neither facility has been providing abortions, so there was no need to have those supplies on hand. The supplies were already on order at the time of the inspections, and they are now on hand at both facilities. DHSS also noted that the Columbia facility did not have an autoclave log, which we have since put in place.

6. The Department also raised some concerns specific to the Kansas City facility, including a concern about the packaging of speculums (which, given that we seek to provide only medication abortion at this facility are only used for family planning patients and not for abortion). The change DHSS requested during the inspection is a simple one—merely storing clean speculums in individual plastic or paper bags rather than in bulk. This change has already been made. Similarly, DHSS's concern about the "traffic pattern" in the decontamination/sterilization room at the Kansas City facility has already been addressed by simply moving the facility's autoclave to a different location in the room. The Department's requests for changes in the storage location of personal protective equipment and medication

have also already been addressed, and all corrugated cardboard boxes have also been removed at the Department's request.

7. The Department also requested minor additions to Comprehensive Health's quality assurance program, specifically that we add categories for certain post-abortion outcomes to our program. This was done immediately following the Columbia inspection and was therefore already corrected by the time of the Kansas City inspection, which is why the letter regarding the latter facility does not raise this concern.

8. The remaining items raised by DHSS in its post-inspection letters (for example, requesting other minor policy changes and requesting that a bathroom exhaust system be modified, McQuade Decl. Ex. B), are all similarly straightforward to address. However, as our attorneys have explained to DHSS in correspondence, because Comprehensive Health's physicians do not currently have hospital privileges that meet the requirements of the Hospital Relationship Restriction and/or the Settlement, and DHSS therefore will not grant Comprehensive Health a license at either facility, it would be a waste of our money and staff resources to make the remaining requested changes at this time. McQuade Decl. Ex. C.

Communications with Hospitals in the Kansas City and Columbia Areas

9. Attached as Exhibit B are the staff bylaws and new provider application for Boone Hospital Center in Columbia, Missouri. As I stated in my initial declaration, Comprehensive Health's physicians cannot meet the requirement that they identify a physician currently on staff at Boone who will provide emergency backup coverage.

10. Attached as Exhibit C are communications I and my staff had with staff at Truman Medical Center, a Kansas City area hospital, in an attempt to obtain information about

the hospital's requirements for privileges. As I stated in my initial declaration, the hospital refused to share the staff bylaws.

11. Attached as Exhibit D are communications I had with St. Luke's Hospital, in Kansas City, attempting to obtain the hospital's staff bylaws. As I stated in my initial declaration, despite Dr. Yeomans submitting an application request, as the hospital directed him to do, the hospital refused to share the staff bylaws with us.

12. Attached as Exhibit E are my communications with a representative of the University of Kansas Hospital, including the staff bylaws that were provided to me. As I stated in my initial declaration, Comprehensive Health's physicians cannot meet the hospital's requirements that they by on medical school faculty and that they undergo evaluations of their inpatient treatment of patients.

13. Attached as Exhibit F are my communications with St. Joseph Medical Center's Director of Physician Recruitment in an attempt to obtain information regarding the hospital's privileging process, including correspondence from the hospital indicating that it would not work with Planned Parenthood.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: January 31, 2017

/s/ Laura McQuade
Laura McQuade

EXHIBIT A

Planned Parenthood
Care. No matter what.

Planned Parenthood
Federation of America

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Missouri Department of Health and Senior Services
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Jefferson City, MO 65102-0570
John.Langston@health.mo.gov

VIA EMAIL

January 13, 2017

Dear Mr. Langston:

We write to provide an update regarding the status of Dr. Ronald Yeomans' hospital privileges near Comprehensive Health of Planned Parenthood Great Plains' ("Planned Parenthood") Brous health center in Kansas City. Dr. Yeomans applied for Affiliate Staff privileges at Menorah Medical Center ("Menorah") in 2016. As you know, Menorah is one of the hospitals listed in the 2010 settlement agreement at which privileges to perform surgery would be deemed sufficient to meet the staff privileges requirement of 19 CSR 30-30.060(1)(C)(4).

Planned Parenthood received notification from Menorah this week that Dr. Yeomans has been granted Active Staff privileges at the hospital. The email and letter providing that notification are attached hereto, as is a copy of Menorah's staff bylaws. As Affiliate Staff is actually the appropriate category of privileges for Dr. Yeomans, Planned Parenthood staff has reached out to the hospital to request that Dr. Yeomans' privileges be changed from Active Staff to Affiliate Staff, and have been assured that this correction will be made at the hospital's next board meeting.

Planned Parenthood staff is still in the process of working with Menorah to clarify the status of Dr. Moore's privileges, and we will provide further information as soon as it is available.

Please advise us within the next 7 days whether the information provided above and in the attached documents regarding Dr. Yeomans' privileges at Menorah changes DHSS's position, most recently expressed in your November 18, 2016 letter, as to whether Planned Parenthood is in compliance with the privileges requirement

of the settlement agreement. As we mentioned in prior correspondence, the remaining items noted in your November 2, 2016 letter regarding the Brous center under the heading 19 CSR 30-30.0601(B)(8) require only minor adjustments to policies and practices around infection control which Planned Parenthood, as an experienced abortion provider, is prepared to quickly remedy once you have confirmed that our physician(s) have the appropriate privileges and that we can therefore move forward with the licensing process.

Thank you for your consideration.

Sincerely,

Melissa Cohen
Planned Parenthood Federation of America
123 William Street
New York, NY 10038
(212) 261-4649

Arthur Benson
Arthur Benson & Associates
4006 Central Avenue
Kansas City, Missouri 64111
(816) 531-6565

cc via email:

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Cohen, Melissa <melissa.cohen@ppfa.org>

FW: Menorah Board Letter Approval

1 message

Smith, Janet <Janet.Smith@ppgreatplains.org> Thu, Jan 12, 2017 at 3:56 PM
To: "Cohen, Melissa" <Melissa.Cohen@ppfa.org>

From: Rachelle.Meyer@hcamidwest.com [mailto:Rachelle.Meyer@hcamidwest.com]
Sent: Tuesday, January 10, 2017 8:07 AM
To: Smith, Janet <Janet.Smith@PPGreatplains.org>
Subject: Menorah Board Letter Approval

Please see attached.

Rachelle Meyer

Credentialing Coordinator

Menorah Medical Center

Medical Staff Services

Ph: 913-498-6624

PP Great Plains works to ensure that every individual has the knowledge opportunity and freedom to make informed, private decisions about reproductive and sexual health.

Planned Parenthood Great Plains

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MENORAH MEDICAL CENTER
5721 W 119th Street, Overland Park, KS 66209

HCA MIDWEST HEALTH

November 16, 2016

Ronald Yeomans, MD
4401 W 109th St Suite 200
Overland Park, KS 66211

Dear Dr. Yeomans:

I am pleased to inform you that, upon the recommendation of the Medical Executive Committee, your appointment to the Active Medical Staff of Menorah Medical Center in the Department of Obstetrics and Gynecology, and the clinical privileges you requested were approved by the Board of Trustees at its meeting 11/16/2016.

Your appointment to the Active Category begins 12/1/2016 and ends 12/31/2017. Initial appointments and clinical privileges are provisional and subject to focused professional practice evaluation (FPPE). Your FPPE will be performed by the Department Chairperson or he/she may designate another physician in the department with the necessary clinical expertise to perform that evaluation.

The Mid-America Division of HCA has developed a process to synchronize everyone's Medical Staff appointment expiration date to coincide with their month of birth. The goal is to streamline the credentialing process and require one application for providers who have privileges at multiple HCA Mid America Division facilities. This was approved by the Board in 2015.

At the end of the project, those born in an even year will be reappointed in an even year and those born in an odd year will be reappointed in an odd year. The expiration date will be the last day of your birth month. In order to transition you into the synchronized cycle your current appointment expiration date has been adjusted.

You will be asked to complete a reappointment application 6 months prior to your end date. Please complete the application for reappointment when requested, at that time your reappointment to the Medical Staff will be considered in accordance with the provisions in the Medical Staff Bylaws.

We appreciate your interest in Menorah Medical Center, and look forward to working with you. If we may be of any service to you, please don't hesitate to contact the Medical Staff Office at (913) 498-6624.

Sincerely,

Charles Laird
Chief Executive Officer

Menorah Medical Center

Delineation of Privileges

Provider: Ronald N Yeomans, MD
ID: H2000049478
Status: Current
Category: Active
Facility Status:

Privileges for: Obstetrics and Gynecology

Privilege	Status	Decision By	Original Date	Start Date	End Date	Condition
Documentation of Advanced Fetal Assessment and Monitoring Course	Approved	Board of Trustees	11/16/2016	12/01/2016	12/31/2017	
Documentation of Operative Vaginal Delivery Course	Approved	Board of Trustees	11/16/2016	12/01/2016	12/31/2017	
Documentation of Managing Shoulder Dystocia Course	Approved	Board of Trustees	11/16/2016	12/01/2016	12/31/2017	
Documentation of Postpartum Hemorrhage Course	Approved	Board of Trustees	11/16/2016	12/01/2016	12/31/2017	
Dilatation and curettage, suction curettage	Approved	Board of Trustees	11/16/2016	12/01/2016	12/31/2017	

MENORAH MEDICAL CENTER

MEDICAL STAFF BYLAWS

December 18, 2014

Table of Contents

1 ARTICLE ONE: NAME, PURPOSES & RESPONSIBILITIES

1.1. NAME

The name of the Medical Staff shall be the "Medical Staff of **Menorah Medical Center**."

1.2. PURPOSES AND RESPONSIBILITIES

The purpose and responsibilities of the medical staff are:

To provide a formal organizational structure through which the Medical Staff shall carry out their responsibilities and govern the professional activities of its members and other individuals with clinical privileges, and to provide mechanisms for accountability of the Medical Staff to the Board. These Bylaws shall reflect the current organization and functions of the Medical Staff.

To provide patients with the quality of care that is commensurate with acceptable standards and available community resources;

To collaborate with the Hospital in providing for the uniform performance of patient care processes throughout the Hospital.

To serve as a primary means for accountability to the Board concerning professional performance of Practitioners and others with clinical privileges authorized to practice at the Hospital with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in the quality assessment, performance improvement, risk management, case management, utilization review and resource management, and other Hospital initiatives to measure and improve performance.

To provide mechanisms for recommending to the Board the appointment and reappointment of qualified Practitioners, and making recommendations regarding clinical privileges for qualified and competent Healthcare Professionals.

To provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills;

To adopt Rules and Regulations for the proper functioning of the Staff, and the integration and coordination of the Staff with the functions of the Hospital;

To provide a means for communication and conflict management with regard to issues of mutual concern to the Staff, Administration, and Board;

1.2.1. To participate in identifying community health needs and establishing appropriate institutional goals;

1.2.2. To assist the Board by serving as a professional review body in conducting professional review activities, which include, without limitation, focused professional practice evaluations, ongoing professional practice evaluations, quality assessment, performance improvement, and peer review.

1.2.3. To pursue corrective actions with respect to members of the Medical Staff or those individuals granted clinical privileges, when warranted.

1.2.4. To monitor and enforce compliance with these Bylaws, Rules and Regulations, and Hospital policies.

1.2.5. To maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State, and local laws and regulations.

1.2.6. To establish criteria for the delineation of clinical privileges and provide mechanisms for recommending to the Board the appointment and reappointment of qualified Practitioners and making recommendations regarding clinical privileges for qualified and competent applicants.

1.3. **ORGANIZED HEALTH CARE ARRANGEMENT; HIPAA COMPLIANCE.**

1.3.1. The Hospital and all members of the Medical Staff shall be considered members of, and shall participate in, the Hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one healthcare provider. An OHCA allows the Hospital to share information with the Physicians and the Physicians' offices for purposes of payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Physicians, Advanced Practice Professionals with clinical privileges or practice prerogatives and Dependent Healthcare Professionals. Each Medical Staff member, each Physician with temporary privileges, Advanced Practice Professional with clinical privileges or practice prerogatives and Dependent Healthcare Professional agrees to comply with the Hospital's policies as adopted from time to time regarding the use and disclosure of individually identifiable health information ("IIHI") and protected health information ("PHI"), as those terms are defined by HIPAA or as any similar terms are defined by more stringent state law (collectively, "IIHI/PHI").

2 ARTICLE TWO: APPOINTMENT/REAPPOINTMENT

2.1 REQUIREMENTS FOR MEMBERSHIP AND GENERAL QUALIFICATIONS

The Medical Staff includes fully licensed Physicians and other Practitioners permitted by law and by the Hospital to provide patient care within the Hospital, and whom the Board of Trustees appoints. Medical Staff membership is a privilege extended by the Hospital, and not a right of any Physician, Practitioner or other person. Membership and/or the permission to exercise clinical privileges shall be extended to and exercised only by those individuals who continuously meet the requirements of these Bylaws.

2.1.1 Patients may be admitted to the Hospital only on the orders of a Physician (MD/DO). Hospital patients must be under the care of a Member of the Medical Staff or under the care of a Practitioner who shall be directly under the supervision of a Member of the Medical Staff. All patient care shall be provided by or in accordance with the orders of a Practitioner who meets the Medical Staff criteria and procedures for the privileges granted, who shall have been granted privileges in accordance with those criteria by the Board of Trustees, and who shall be working within the scope of those granted privileges.

2.1.2 Patients admitted by Licensed Independent Practitioners who are not physicians, including DDS, DMD, DPM, shall be under the care of a physician with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting Practitioner.

2.1.3 Patients admitted by licensed Practitioners who are not independent Practitioners, including physician assistants (PA), certified registered nurse anesthetist, a certified nurse midwives, advanced practice registered nurse practitioner and clinical psychologist, shall be under the care of a physician.

2.2 Appointment to the Medical Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Board of Trustees or as are afforded to APPs when clinical privileges are granted to an individual in this category. For purposes of these Bylaws, "membership in" is used synonymously with "appointment to" or "reappointment to" the Medical Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. The Board of Trustees has determined the categories of healthcare professionals eligible for Medical Staff membership and/or clinical privileges, as defined in these Bylaws. All Medical Staff members and individuals with clinical privileges are subject to these Bylaws and Rules and Regulations. Only those individuals meeting all Threshold Eligibility Criteria shall be eligible to apply for appointment to the Medical Staff or clinical privileges, and these professional criteria shall apply uniformly to all applicants:

2.3 THRESHOLD ELIGIBILITY CRITERIA

To be eligible to apply for initial appointment or reappointment to the Medical Staff, or to apply for clinical privileges, a Practitioner must be a physician, dentist, oromaxillofacial surgeon, or podiatrist.

To be eligible for clinical privileges as an Advanced Practice Professional (APP) an individual must be an physician assistants (PA), certified registered nurse anesthetist, a certified nurse midwives, advanced practice registered nurse practitioner and clinical psychologist, and;

2.3.1 Have proof of identity and either US citizenship or evidence of status as a lawful permanent resident of the US; and,

2.3.2 Have a current, unlimited, unrestricted, active (as defined in these Bylaws) legal license to practice in his or her respective profession in the state of Kansas, which license permits him or her to practice in the Hospital setting and authorizes him or her to receive and examine patients, diagnose conditions and prescribe and implement a treatment plan and to prescribe all medications necessary for the treatment of conditions and diagnoses within the Practitioner's area of practice, independent of review, supervision or prescription by another Practitioner, and have never had a license to practice revoked or suspended by any state licensing agency, or in the case of an APP, to practice within the full scope of licensure with any supervision as may be required by law; and,

2.3.2.1 If the applicant is an active duty military Practitioner, and will be practicing exclusively within the scope of military duties for patients who are members of the armed forces or their dependents, then current, unlimited, unrestricted, active licensure from any State shall be accepted.

2.3.2.2 If the applicant is a telemedicine Practitioner located in a different State, the applicant must also possess current, unlimited, unrestricted, active licensure in that State.

2.3.2.3 If the applicant is an out-of-state Practitioner who will be providing patient care in this state under an exception to state licensure requirements, the exception must be verified with the State licensure board and documented. Any conditions associated with the exception (i.e., that the exception requires that the Practitioner must be licensed in his/her home State) must also be verified and documented.

2.3.3 Where applicable to his or her practice, have a current, unrestricted Federal DEA registration valid for prescribing within the state of Kansas and which permits him or her to prescribe all medications necessary for the treatment of conditions and diagnoses within the Practitioner's area of practice, independent of review, supervision or prescription by another Practitioner; and,

2.3.4 Can document his or her (i) background, experience, training and demonstrated competence; (ii) adherence to the ethics of their profession; (iii) good reputation and character, including the applicant's mental and emotional stability and physical health status, and (iv) ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by him or her in the Hospital will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner; and

2.3.5 Be located (office and residence) within the geographic service area of the Hospital, as defined by the Board of Trustees, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital and

2.3.6 Be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and Emergency Department patients in a prompt, efficient, and conscientious manner. ("Appropriate coverage" means coverage by another member of the Medical Staff with specialty-specific privileges equivalent to the Practitioner for whom he or she is providing coverage.) Compliance with this eligibility requirement means that the Practitioner must document that he or she is willing and able to:

2.3.6.1 Respond within 15 minutes, via phone, to STAT pages from the Hospital and respond within 30 minutes, via phone, to all other pages; and,

2.3.6.2 Appear in person to attend a patient within 30 minutes, when requested to do so by the Practitioner caring for the patient at the Hospital;

2.3.7 For APPs, have the necessary coverage by a sponsoring or supervising physician as required by State laws and regulations, or the supervision required in association with the clinical privileges granted to the APP; and,

2.3.8 Have current, valid professional liability insurance coverage in a form acceptable to the Hospital, including insurance through a carrier authorized to do business in the State of Kansas as a licensed provider of professional malpractice insurance, insurance for the clinical privileges requested, and with limits of at least $1 million for each claim and $3 million in aggregate; and,

2.3.9 Have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state government or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same; and,

2.3.10 Have never been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program, as verified by screening ineligible persons against the OIG, GSA, and State exclusion list"; and,

2.3.11 Have never had Medical Staff appointment, employment or clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct; and,

2.3.12 Have never resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation; and,

2.3.13 Have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence; and,

2.3.14 Agree to fulfill all responsibilities regarding emergency service call coverage for his or her specialty as may be required by the Hospital and the Medical Staff; and,

2.3.15 Have or agree to make appropriate coverage arrangements (as determined by the Credentials Committee) with other members of the Medical Staff for those times when the individual will be unavailable; and,

2.3.16 Demonstrate recent clinical activity in his or her primary area of practice during the last two years; and,

2.3.17 Meet any current or future eligibility requirements that are applicable to the clinical privileges being sought; and,

2.3.18 If applying for privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract; and,

2.3.19 Have successfully completed:

2.3.19.1 Graduation from a school of medicine accredited by the Association of American Medical Colleges or the American Association of Colleges of Osteopathic Medicine, or a school of dentistry accredited by the Commission on Accreditation of the American Dental Association, or a school of podiatry accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association, or other accredited school appropriate to his or her profession. If the applicant is a physician who is a foreign medical graduate, he/she must have successfully completed the Education Commission for Foreign Medical Graduate (ECFMG) or an accredited fifth pathway program, and have verification of graduation from a foreign medical school; and,

2.3.19.2 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 (ACGME) or the American Osteopathic Association (AOA) 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 or oromaxillofacial surgeons 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; and,

2.3.19.3 Participation in continuing education as related to the clinical privileges requested; and,

2.3.19.4 For a physician, a dentist, an oromaxillofacial surgeon, or a podiatrist, to be Board Certified or Board Eligible, as follows:

2.3.19.4.1 All initial physician applicants must be either Board Certified, Board Eligible or demonstrate that he or she has obtained the training requisite to board certification in the areas of proposed practice. For physicians, they must be board certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS"), or the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association (AOA). For podiatrists, the board certification program accepted by the Hospital is the American Board of Podiatric Surgery (ABPS) or the American Board of Podiatric Medicine (ABPM), and for dentists and oromaxillofacial surgeons the board certification program accepted by the Hospital is the American Board of Oral/Maxillofacial Surgeons (ABOMS) or the American Dental Association (ADA), and for optometrists the American Board of Optometry (ABO). If the applicable board eligibility requirements include the successful completion of a residency program, this residency program must be completed through an approved postgraduate training program. 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 other applicants must have successfully completed an approved postgraduate training program in their respective profession.

2.3.19.4.2 Continued Medical Staff membership will require a physician who is Board Eligible to obtain board certification in the proposed area of practice within the board eligibility timeframe as defined by a hospital-recognized board. In the event the certification board has not defined an eligibility period, it shall be five years from graduation. Notwithstanding the foregoing, the Board shall have the power to waive the board certification requirement under extraordinary circumstances. There shall be documentation of the need for the talents of the applicant prepared by the Credentials Committee for review and recommendation by the Medical Executive Committee and for review and action by the Board. Extraordinary circumstances should be considered only if (i) the applicant has a current, unrestricted license as required by the State in which the Hospital is located, (ii) the applicant is not an Ineligible Person, and (iii) the applicant has achieved extraordinary recognition in the field of medicine as related to the needed talents documented by the Credentials Committee.

2.3.19.5 The requirement outlined in these Medical Staff Bylaws for satisfactory completion of approved postgraduate training, and the board certification requirements outlined in these Medical Staff 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 Medical Staff Bylaw provision.

2.4 WAIVER OF THRESHOLD ELIGIBILITY CRITERIA

2.4.1 When an individual does not satisfy one or more of the Threshold Eligibility Criteria outlined above, the individual shall be notified by the CPC that the Request for Consideration (RFC) or the Reappointment Request for Consideration (RRFC) that does not satisfy a Threshold Eligibility Criterion will not be processed.

2.4.2 Any individual who does not satisfy one or more of the Threshold Eligibility Criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

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

2.4.4 The Medical Executive Committee shall review the recommendation of the Credentials Committee and make a recommendation to the Board of Trustees regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

2.4.5 No applicant is entitled to a waiver or to a hearing if the Board of Trustees determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, it is a final determination that the individual is ineligible to request appointment or clinical privileges based on current information.

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

2.4.7 A Request for Consideration (RFC) or Reappointment Request for Consideration (RRFC) that does not satisfy a Threshold Eligibility Criterion will not be processed until the Board of Trustees has determined that a waiver should be granted.

2.5 FACTORS FOR EVALUATION OF APPLICATION

When a Request for Consideration (RFC) or the Reappointment Request for Consideration (RRFC) is received that is complete and meets all Threshold Eligibility Criteria, it will be processed by the CPC and submitted to the Hospital as an application. Six general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated by the Medical Staff as part of the appointment and reappointment processes, as reflected in the following factors:

2.5.1 CURRENT COMPETENCE, EXPERIENCE AND JUDGMENT

The applicant must document his/her relevant training and experience, and current clinical competence, skills and judgment including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided, with sufficient adequacy, as determined at the discretion of the Medical Executive Committee and the Board of Trustees, to demonstrate that patients receiving healthcare services from him/her will receive care of the generally recognized professional level of quality and efficiency established by the Hospital. Evidence of current competence and experience shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of current competence and experience shall also include, but not be limited to, documentation of continuing medical education, the results of performance improvement and peer review, and recommendation(s) provided by Department Chairperson(s).

2.5.2 CONDUCT/BEHAVIOR

The applicant must be able to demonstrate good reputation and character including the ability to work cooperatively with others and to treat others within the Hospital with respect. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of ability to display appropriate conduct and behavior shall also include, but not be limited to, a review of conduct during the previous term(s) of appointment and recommendation(s) provided by Division and Department Chairperson(s).

2.5.3 PROFESSIONAL ETHICS AND CHARACTER

The applicant must demonstrate adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession. By virtue of applying for Medical Staff membership or clinical privileges, and agreeing to abide by the Medical Staff Bylaws, the applicant shall agree to abide by applicable provisions of the Code of Conduct of HCA, and the code of ethical business and professional behavior of this Hospital.

2.5.4 HEALTH STATUS/ABILITY TO PERFORM

The applicant shall possess the ability to safely and competently perform the clinical privileges requested. In the event that the applicant has a physical or mental health issue that adversely affects his/her ability to practice within the clinical privileges requested, the applicant shall notify the President of the Medical Staff. Upon receipt of such notification, the President of the Medical Staff will meet with the applicant to determine the extent of the health issue. If it is determined that the health issue does not adversely affect the applicant's ability to perform the essential functions of the clinical privileges requested, the President of the Medical Staff and applicant will discuss whether there is a reasonable accommodation that would enable the applicant to perform such functions. If reasonable accommodation is necessary, the Hospital will provide such accommodation to the extent required by law, or if not so required, as determined to be appropriate within the sole discretion of the Hospital.

2.5.5 INTERPERSONAL AND COMMUNICATION SKILLS

The applicant shall possess an ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and to communicate in English in an understandable manner sufficient for the safe delivery of patient care (as determined in the sole discretion of the Hospital), both verbally and in writing. Hospital records, including patients' medical records, shall be recorded in a legible fashion, in English.

2.5.6 COMMITMENT TO QUALITY CARE

The applicant shall demonstrate recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.6 NO ENTITLEMENT TO APPOINTMENT

No individual is entitled to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

2.6.1 Is licensed to practice a profession in this or any other state;

2.6.2 Is a member of any particular professional organization;

2.6.3 Is certified by any specialty certification board;

2.6.4 Resides in the geographic service area of the Hospital;

2.6.5 Is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity; or,

2.6.6 Has/had Medical Staff membership or clinical privileges in another hospital or health care organization.

2.7 HOSPITAL NEED AND ABILITY TO ACCOMMODATE

No person shall be appointed to the Medical Staff or shall be granted clinical privileges if the Hospital is unable to provide adequate facilities and support services for the applicant or his/her patients. The Board of Trustees may decline to accept, or have the Medical Staff review requests for Medical Staff membership and/or particular clinical privileges in connection with appointment, reappointment, the initial granting of clinical privileges, requests for revision of clinical privileges, the renewal of clinical privileges or otherwise on the basis of the following:

2.7.1 AVAILABILITY OF FACILITIES/SUPPORT SERVICES

Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, and capabilities of the Hospital. Prior to granting of a clinical privilege, the resources necessary to support the requested privilege shall be determined to be currently available, or available within a specified time frame. Resource considerations shall include whether there is sufficient space, equipment, staffing, financial resources or other necessary resources to support each requested privilege.

2.7.2 EXCLUSIVE CONTRACTS

The Board of Trustees may determine, in its exclusive discretion based upon consideration of quality of patient care and as a matter of policy, that certain

Hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the Hospital and qualified Practitioners.

If any exclusive contract would have the effect of preventing a Practitioner with existing clinical privileges from exercising those clinical privileges, the affected Practitioner shall be given notice of the exclusive contract. The affected Practitioner shall not be entitled to any other procedural rights with respect to the decision or the effect of the contract on his/her clinical privileges. The inability of a Practitioner to exercise clinical privileges because of an exclusive contract is not a matter that entitles the Practitioner to a hearing and does not require a report to the state licensure board or to the National Practitioner Data Bank.

2.7.3 MEDICAL STAFF DEVELOPMENT PLAN

The Board of Trustees may decline to accept applications based on the requirements or limitations in the Hospital's Medical Staff development plan which shall be based on identification by the Hospital of the patient care needs within the population served.

2.7.4 EFFECTS OF DECLINATION

Refusal to accept or review requests for Medical Staff membership or clinical privileges based upon Hospital need and ability to accommodate, as described in this Section, shall not constitute a denial of Medical Staff membership or clinical privileges and shall not entitle the individual to any procedural rights of hearing or appeal. Any portion of the application which is accepted (e.g., requests for clinical privileges that are not subject to a limitation) shall be processed in accord with these Bylaws.

2.8 BASIC OBLIGATIONS OF MEMBERSHIP AND CLINICAL PRIVILEGES

By submitting Request for Consideration, Recredentialing Request for Consideration or application for Medical Staff membership and/or a request for clinical privileges, the Practitioner signifies agreement to fulfill on a continuing basis the following obligations of holding Medical Staff membership and/or clinical privileges. The Practitioner shall agree to:

2.8.1 Appear by phone or in person for any requested interviews regarding his/her application, or subsequent to appointment or the granting of clinical privileges, to appear for any requested interviews related to questions regarding the applicant's performance;

2.8.2 Provide continuous care to his/her patients at the generally recognized professional level of quality and efficiency established by the Hospital; delegate in his/her absence the responsibility for diagnosis and/or care of his/her patients only to a Practitioner who is qualified and approved by the Hospital to undertake this responsibility by the granting of appropriate clinical privileges; and seek consultation whenever necessary, and in accordance with the consultation policies of the Medical Staff Rules and Regulations;

2.8.3 Abide by these Bylaws, the Rules and Regulations, Medical Staff Policies, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital in force during the entire term of appointment or clinical privileges;

2.8.4 Abide by all local, State and Federal laws and regulations, Joint Commission and other accreditation standards as they apply within the Hospital, and State licensure and professional review regulations and standards, as applicable to the applicant's professional practice;

2.8.5 Participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as may be assigned;

2.8.6 Within the scope of clinical privileges granted, to provide on-call coverage for emergency care services within his/her clinical specialty, as required by the Hospital or the Medical Staff;

2.8.7 Comply with clinical practice protocols and evidence-based medicine guidelines that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;

2.8.8 Participate in necessary training and utilize the electronic record systems or other technology in use by the Hospital to prepare a patient record for each patient;

2.8.9 Complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital;

2.8.10 Utilize the Electronic Health Record (EHR) system of the Hospital;

2.8.11 Cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;

2.8.12 Participate in peer review, quality assessment, performance improvement, risk management, case management/resource management, and other review and improvement activities as requested;

2.8.13 Cooperate with all oversight activities related to utilization and medical appropriateness;

2.8.14 Participate in continuing education to maintain clinical skills and current competence;

2.8.15 Refrain from illegal fee splitting or other illegal inducements relating to patient referral;

2.8.16 Refrain from delegating responsibility for hospital patients to any individual who is not appropriately licensed, qualified or adequately supervised;

2.8.17 Refrain from deceiving patients as to the identity of any individual providing treatment or services;

2.8.18 Seek consultation whenever required or necessary;

2.8.19 Perform all services and conduct himself/herself at all times in a cooperative and professional manner;

2.8.20 Promptly pay any applicable dues, assessments, and/or fines;

2.8.21 Complete the Hospital's new physician/practitioner orientation within a timeframe defined by the hospital;

2.8.22 Agree that the Hospital may obtain an evaluation of the applicant's performance by a consultant selected by the Hospital if the Hospital considers it appropriate;

2.8.23 Comply with the Medical Staff Policy for Practitioner Health & Wellness by immediately submitting to an evaluation as required when there are identified, credible concerns with the individual's ability to safely and competently care for patients; and,

2.8.24 Agree that, if there is any misstatement in, or omission from, the Request for Consideration, Recredentialing Request for Consideration or application, the Hospital may stop processing (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual's response and provide a recommendation to the Medical Executive Committee. The Medical Executive Committee will recommend to the Board of Trustees whether the application should be processed further. In either situation, there shall be no entitlement to a hearing or appeal.

2.9 TERMS OF APPOINTMENT

Terms of membership and/or the granting of clinical privileges shall be for a period that may be less than, but shall not exceed two years (24 months).

2.10CREDENTIALS VERIFICATION

Upon the receipt of a completed Request for Consideration (RFC) or Recredentialing Request for Consideration (RRFC) form, the Credentials Processing Center shall arrange to verify the qualifications and obtain supporting information relative to the RFC or RRFC. The Credentials Processing Center shall consult primary sources of information about the individual's credentials, where feasible. Completion of a background check, verifications of licensure, controlled substance registration, specialty board certification, and professional liability claims history, a query of the NPDB, queries of the OIG Sanction Report, GSA List, and State exclusion list, if applicable, and collection of any other information necessary to verify that the individual satisfies all Threshold Eligibility Criteria shall be done within 150 days prior to the Board of Trustees receiving the application. If there are delays in completing the RFC or RRFC, any of these verifications or queries that were done more than 150 days before the Board of Trustees is scheduled to receive the application shall be repeated. Verification may be made by a letter or computer printout obtained from the primary source or it may be verbally or electronically transmitted (e.g., telephone, facsimile, email, Internet) information when the means of transmittal is directly from the primary source to the Credentials Processing Center and the verification is documented. If the primary source has designated another organization as its officially-designated agent in providing information to verify credentials, the Credentials Processing Center (CPC) may use this other organization as the designated equivalent source. The Credentials Processing Center shall promptly notify the individual of any problems in obtaining required information. Any action on an application shall be withheld until it is completed; meaning that all information has been provided and verified, as defined in these Bylaws.

2.10.1 BURDEN ON APPLICANT TO PROVIDE COMPLETE INFORMATION

2.10.1.1 Any individual requesting initial appointment, reappointment, or clinical privileges shall be sent (1) a letter that outlines the Threshold Eligibility Criteria for appointment and clinical privileges, and (2) a Request for Consideration (RFC) or a Recredentialing Request for Consideration (RRFC) form which requests proof that the individual meets the Threshold Eligibility Criteria for appointment, reappointment and clinical privileges. A completed RFC or RRFC form with copies of all required documents must be returned to the Credentialing Processing Center. The Credentialing Processing Center (CPC) shall not have any obligation to process any RFC or R-RFC unless it is complete. Only after a completed RFC or RRFC has been received and all information verified, and the individual has been deemed eligible to apply, shall the CPC submit the information to the Hospital

as an application. There is no right to a hearing because of failure to submit a complete RFC or RRFC or because of a determination of ineligibility.

2.10.1.2 RFCs may be provided to residents or fellows who are in the final six months of their training. Such RFCs may be processed, but final action shall not be taken until all applicable Threshold Eligibility Criteria are satisfied.

2.10.1.3 Individuals seeking appointment, reappointment and/or clinical privileges have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges or scope of practice, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

2.10.1.4 Individuals seeking appointment, reappointment and/or clinical privileges have the burden of providing evidence that all the statements made and information given on the RFC or RRFC are accurate and complete.

2.10.1.5 The individual seeking appointment, reappointment, or clinical privileges is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

2.10.1.6 An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

2.10.1.7 Medical Staff Services shall oversee the process of analyzing the information gathered by the CPC, and confirming that all references and other information or materials deemed pertinent have been received.

2.10.2 REQUEST FOR CONSIDERATION (RFC) / RECREDENTIALING REQUEST FOR CONSIDERATION (RRFC)

An RFC or RRFC shall contain a request for specific clinical privileges if privileges are being sought, and shall require detailed information concerning the individual's professional qualifications. In addition to other information, the RFC/RRFC shall seek the following:

2.10.2.1 Identifying information, including full name, social security number, date of birth, any aliases, and addresses of office & residence, and any other information required to verify identification or background. Verification of identity may be performed by a current/licensed notary public and documented with a notarized statement, or verification may be performed by the staff of Medical Staff Services provided that the individual physically presents himself/herself for the verification process.

2.10.2.2 For new applicants, an attestation of US citizenship, or evidence that the individual is in the US legally and has the required permission(s) to work in this country. For individuals who are not US citizens who are requesting reappointment or renewal of privileges, evidence of a current visa and current work permit shall be required. The requirements of this Section do not apply to an individual who is residing and working from a foreign country (i.e., a foreign-based telemedicine Practitioner) because the immigration laws of the US do not apply.

2.10.2.3 For a new applicant, written permission from the individual for a background check, and completion of the background check.

2.10.2.4 Evidence of current, unlimited, unrestricted licensure in the State of Kansas and information from the individual regarding any current or past licensure in any healthcare profession or in any other state or other jurisdiction;

2.10.2.5 For individuals requesting medication prescribing privileges, evidence of a current, unlimited, unrestricted Federal DEA listing an in-state address;

2.10.2.6 For a new applicant, the names and addresses of educational institutions, and dates of attendance, for undergraduate and postgraduate education, including professional degrees earned, and in the case of a foreign graduate, ECFMG certificate;

2.10.2.7 For individuals for appointment who are not newly graduated from residency or fellowship program within the last year, and for individuals for reappointments or renewal of clinical privileges, documentation of the individual's participation in continuing education, specifically as related to the clinical privileges requested;

2.10.2.8 The names and contact information for three peers practicing in the same or like professional discipline as the individual, shall be requested from the individual, of which at least two peers shall provide a written evaluation of the individual's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and ability to perform the clinical privileges requested before an application will be considered complete. The peers shall be persons with current knowledge of the individual who can provide an unbiased appraisal;

2.10.2.9 Information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of board certification;

2.10.2.10 Information regarding all current healthcare facility affiliations, including the name and address of the facility(s) and dates of affiliation

and reasons for termination of Medical Staff membership and limitation, reduction or termination of clinical privileges;

2.10.2.11 Evidence of current professional liability insurance, including the name of the carrier, amount and dates of coverage, and professional practice covered;

2.10.2.12 Medicare Provider NPI for the individual provider (e.g., not a NPI for a group practice);

2.10.2.13 Information as to any current, or pending sanctions affecting participation in any Federal Health Care Program, or any actions which might cause the individual to become an Ineligible Person, as well as any sanctions from a professional review organization;

2.10.2.14 Accurate and complete disclosure with regard to the following queries:

2.10.2.14.1 Whether the individual's professional license or controlled substance registration (DEA, state or local), in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the individual has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;

2.10.2.14.2 Whether the individual has had any voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another Hospital or other healthcare facility;

2.10.2.14.3 Whether the individual has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the individual; and,

2.10.2.14.4 Whether the individual has ever been subject to a criminal action, as defined in these Bylaws, or whether any such action is pending.

2.10.2.15 A statement from the individual that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting, pursuant to Section 2.5.4;

2.10.2.16 Evidence that the individual has complied with the health screening and immunization requirements of the Hospital. (e.g., influenza vaccinations),

2.10.2.17 All Physicians and other Practitioners shall submit a signed Physician Acknowledgement Statement. The Physician or other Practitioner must complete the acknowledgment at the time he or she is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient to the hospital (i.e., when temporary privileges have been granted). Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital. Physicians, other Practitioners, and Advanced Practice Professionals will also sign a Confidentiality and Security Agreement at the time of submitting a RFC

for initial appointment and periodically as such Agreement may be revised, and shall agree that as a condition of membership or holding clinical privileges, the individual shall abide by the privacy and confidentiality policies of the Hospital. Completed Agreements will be maintained in the individual's credentials file.

2.10.2.18 Unless the individual is applying for Medical Staff membership only, all RFCs and RRFCs must include a specific written request for clinical privileges using prescribed forms. Requests for clinical privileges shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the individual meets the criteria for each of the privileges requested.

2.10.3 REQUIRED CONSENTS AND AGREEMENTS

Once completed and all information verified by the CPC, the RFC/RRFC shall be turned over to the Hospital for processing as an application. By requesting an RFC, RRFC, application, and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

2.10.3.1 ACCEPTANCE TO BE BOUND TO BYLAWS AND OTHER GOVERNING DOCUMENTS

The individual agrees that he/she has received and is responsible to read the current Medical Staff Bylaws, Rules and Regulations, and Policies and agrees to be bound by them, including any amendments to Bylaws, Rules and Regulations and Policies as may be adopted pursuant to Article Twelve;

2.10.3.2 AGREEMENT TO PROVIDE CONTINUOUS CARE

The individual agrees to provide continuous care to his/her patients, as defined in these Bylaws.

2.10.3.3 CONSENT TO RELEASE OF INFORMATION

The individual consents to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including all health information and medical records necessary to verify the individual's health status as required by these Bylaws and for a new applicant a permission to conduct a background check, and a statement providing absolute immunity and release from civil liability for all individuals requesting or providing information relative to the individual's professional qualifications or background, or evaluating and making judgments regarding such qualifications or background.

2.10.3.4 IMMUNITY FROM LIABILITY

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, Medical Staff appointee, and individual who is granted clinical privileges extends absolute immunity to, and releases from all claims, damages and liability whatsoever:

2.10.3.4.1 The Hospital and the Board of Trustees, any member of the Medical Staff and the Board of Trustees, their authorized representatives, and third parties who provide information for any matter relating to Requests for Consideration, Recredentialing Requests for

Consideration, appointment, reappointment, clinical privileges, or the individual's qualifications for the same;

2.10.3.4.2 Any third party for releasing or disclosing information, including otherwise privileged or confidential information, to any Hospital representative concerning the individual whether the individual is a former or current applicant or Medical Staff appointee.

2.10.3.4.3 The immunity provided by the Medical Staff Bylaws 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:

2.10.3.4.3.1 Applications for appointment and/or clinical privileges;

2.10.3.4.3.2 Periodic reappraisals undertaken for reappointment or for changes in clinical privileges;

2.10.3.4.3.3 Corrective action;

2.10.3.4.3.4 Hearings and appellate reviews;

2.10.3.4.3.5 Patient care audits;

2.10.3.4.3.6 Medical care evaluations;

2.10.3.4.3.7 Utilization reviews;

2.10.3.4.3.8 Other Hospital, staff, department, service, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

2.10.3.4.3.9 Matters or inquiries concerning the credentials of any applicant, Medical Staff appointee, or Practitioner with clinical privileges;

2.10.3.4.3.10 Matters directly or indirectly affecting patient care or the efficient operation of the Hospital; and

2.10.3.4.3.11 Reports to the National Practitioners Data Bank established pursuant to the Act.

2.10.3.4.4 Scope of Section

All of the provisions in this Section 2.10.3.4 are applicable in the following situations, including but not limited to:

2.10.3.4.4.1 Whether or not appointment or clinical privileges are granted;

2.10.3.4.4.2 Throughout the term of any appointment or reappointment period and thereafter;

2.10.3.4.4.3 Should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

2.10.3.4.4.4 As applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure as a member of the Medical Staff.

2.10.3.5 AUTHORIZATION TO OBTAIN INFORMATION FROM THIRD PARTIES

The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on his or her credentials and agrees that any information so provided shall not be required to be disclosed to him or her if the third party providing such information does so on the condition that it be kept confidential (2) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (3) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release information, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations and other documents in their possession, bearing on his or her credentials to any Hospital Representative, and consents to the inspection and procurement by any Hospital Representative of such information, records and other documents.. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

2.10.3.6 BACKGROUND INVESTIGATION

The individual requesting initial appointment or initial clinical privileges shall provide written permission to conduct a background investigation as part of the initial credentials verification process and on an ad hoc basis upon request by the Chief Executive Officer.

Circumstances that may trigger a request for an ad hoc background investigation include, but are not limited to:

2.10.3.6.1 Disciplinary action against the individual's license;

2.10.3.6.2 Sanctions or revocation of the individual's Federal DEA or State narcotic registration;

2.10.3.6.3 Identification of felony or misdemeanor arrests or convictions; or

2.10.3.6.4 Reports of disruptive behavior, harassment, professional misconduct, or alcohol/substance abuse.

2.10.3.7 AUTHORIZATION TO MAINTAIN INFORMATION

The individual authorizes the Hospital to maintain information concerning the individual's specialty, demographic information, training, board certification, licensure and other confidential information in a centralized Practitioner data base for the purpose of making aggregate Practitioner information available for use by the Hospital and its affiliates.

2.10.3.8 AUTHORIZATION TO RELEASE INFORMATION TO THIRD PARTIES

The individual authorizes Hospital representatives to release information to the Hospital's affiliated management entities (e.g., Division office), other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter. The individual also authorizes the Hospital to release confidential information, including peer review and/or quality assurance information, obtained from or about the Practitioner to peer review committees of the Hospital and affiliates of the Hospital for purposes of reducing morbidity and mortality and for the improvement of patient care.

2.10.3.9 HEARING AND APPEAL PROCEDURES

The individual agrees that the hearing and appeal procedures set forth in these Bylaws are the sole and exclusive remedy with respect to any professional review action taken by the Hospital and agrees that, if any adverse action is made with respect to him or her, (1) he or she will follow and exhaust the administrative remedies afforded by the Medical Staff Bylaws and the Hearing Procedure as a prerequisite to any other action, and (2) he or she will have the burden of demonstrating that he or she meets the standards for appointment or continued appointment to the Medical Staff or for the clinical privileges requested.

2.10.3.10 REPORTING

The individual consents to the reporting by any Hospital Representative of information to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986, and to other Federal agencies or to State agencies as required by laws, statutes or regulation, which such Hospital Representative believes in good faith is required by law to be reported.

2.10.3.11 AGREEMENT TO IMMEDIATELY NOTIFY HOSPITAL OF CHANGES IN INFORMATION

The individual shall specifically agree to immediately provide in writing within one business day of being officially notified of a change in status, a notice to the Medical Staff and the Hospital, with or without request, of any new or updated information that is pertinent to the individual's professional qualifications or any question on the RFC/RRFC form, including but not limited to any change in Federal Health Care Program Ineligible Person status, any exclusion from a State Program, any change in licensure in any state, any change in DEA status or status with a State controlled substance regulatory agency, or any exclusion or other sanctions imposed or recommended by the U.S. Department of Health and Human Services or any state, the receipt of a Quality Improvement Organization (QIO) citation, any change in legal status to reside and/or work in the USA, any investigation by a specialty certification board, any payer contract termination, any change in health status, any change in location of office or residence, loss of on-call

coverage, any criminal investigation, termination of or notice of non-renewal of professional liability insurance coverage, initiation of any corrective action by any health care facility or professional organization, and/or a quality denial letter concerning alleged quality problems in patient care.

2.10.3.12 LEGAL ACTIONS

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or privileges and does not prevail on all claims or counts made in the complaint(s) or petition(s), he or she shall reimburse the Hospital and any member of the Medical Staff or Board of Trustees involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees and lost revenues.

2.10.4 APPLICATION PROCESSING

After verification is accomplished and the RFC or RRFC is deemed fully complete and it has been verified that all Threshold Eligibility Criteria have been met, the information shall be submitted as an application and it shall be reviewed and processed as follows:

2.10.4.1 Time Period for Processing: Once an application is deemed complete, it is expected to be processed within 150 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period. If the action of the Board of Trustees has not been taken within 150 days after an application is turned over by the CPC for MSO File Review, the verifications must first be repeated to assure that the information is current before the Board of Trustees takes action.

2.10.4.2 Determination of Clinical Privileges: Determination of initial clinical privileges shall be based upon the professional criteria used in evaluating applicant's credentials for Medical Staff appointment, and the professional criteria established by the Hospital for specific clinical privileges. In the course of development of its recommendation concerning an applicant's request for clinical privileges, the Credentials Committee shall forward to the Chairperson of the applicable Department the applicant's qualifications and request for clinical privileges. This request shall be communicated through a summary of the pertinent information, such as the electronic Cactus profile and supporting documents. Following receipt of the Department Chairperson's recommendation regarding the applicant's clinical privileges, the Credentials Committee shall consider such recommendation and, if the committee concurs, report to the Medical Executive Committee its recommendations for privileges to be granted applicant. The written comments of the Medical Executive Committee, if any, will be forwarded to the Board of Trustees simultaneously with the recommendation of the Credentials Committee. Should the Credentials Committee not concur with the Department Chairperson's recommendation for clinical privileges, the request may be returned to the Department Chairperson for further consideration. The time frame for completion of the Department report(s) shall be within 30 days of receipt of a complete application. For Advanced Practice Registered Nurses (APRNs), since they provide nursing care, treatment

and services, their practice shall be under the supervision and direction of the Chief Nursing Officer (CNO) in addition to Medical Staff oversight. Therefore, the CNO shall make an evaluation and provide recommendations regarding the clinical privileges to be granted to an APRN, and any concerns regarding the clinical privileges requested or level of supervision needed.

2.10.4.3 Credentials Committee Report: The Credentials Committee shall receive from the Department Chairperson and review the application, supporting materials, the report of the Department Chairperson, and any such other available information as may be relevant to the applicant's qualifications. The Credentials Committee shall prepare a written report and recommendation for the Medical Executive Committee as to Medical Staff appointment and Medical Staff category in the case of applicants for Medical Staff membership, the Department/Division to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for completion of the Credentials Committee action shall be at the next regular meeting of the committee following receipt of the Department report, to be within 30 days.

2.10.4.4 Criteria for Additional Inquiry: Additional inquiry shall be conducted by the Department Chairperson, Credentials Committee, or Medical Executive Committee for any of, but not limited to, the reasons listed below. Additional inquiry may include a personal interview with the applicant, a request for a letter of explanation from the applicant, further contact with sources of information, or any other means appropriate to resolving questions about the application. The application shall be deemed incomplete until additional inquiry is completed, and questions about the following matters are explained to the satisfaction of the Department Chairperson, Credentials Committee, Medical Executive Committee or Board of Trustees. Criteria for additional inquiry are:

2.10.4.4.1 Inability to verify through original source documentation any of the information or credentials represented in the application;

2.10.4.4.2 Any unexplained gaps in Medical Staff membership, clinical privileges and/or work history;

2.10.4.4.3 Any other inconsistent or less than favorable information about the applicant's professional qualifications, competence or character, as judged by the Department Chairperson Credentials Committee, Medical Executive Committee or Board of Trustees.

2.10.4.5 Medical Executive Committee Recommendation: The Medical Executive Committee shall receive from the Credentials Committee and review the application, supporting materials, the reports of the Department Chairperson and the Credentials Committee, and any such other available information as may be relevant to the applicant's qualifications. The Medical Executive Committee shall prepare a written report and recommendation for the Board of Trustees as to

Medical Staff appointment and Medical Staff category in the case of applicants for Medical Staff membership, the Department to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. The Board of Trustees shall not take action upon any Credentials Committee recommendations until having received the written comments from the Medical Executive Committee. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for the Medical Executive Committee to decide on a recommendation to the Board of Trustees shall be at the next regular meeting of the committee following receipt of the Credentials Committee report.

2.10.4.6 EFFECT OF MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

2.10.4.6.1 Deferral: The Medical Executive Committee may defer making a recommendation where the deferral is not solely for the purpose of causing delay. A decision by the Medical Executive Committee to defer the application for further consideration shall state the reasons for deferral, provide direction for further investigation, and state time limits for such further investigation. As soon as practical after the deferral, such decision to defer the application shall be followed with a subsequent favorable or adverse recommendation. The Medical Executive Committee may delegate the responsibility for further consideration to the Credentials Committee or Department Chairperson as deemed appropriate.

2.10.4.6.2 Favorable Recommendation: When the recommendation is favorable, the application shall be forwarded promptly to the Board of Trustees for action at the Board of Trustees' next regular meeting.

2.10.4.6.3 Adverse Recommendation: If the recommendation of the Medical Executive Committee is adverse as defined by Article Six of these Bylaws, the President of the Medical Staff shall promptly notify the applicant. Such notice shall contain the information prescribed in Article Six of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in Article Six of these Bylaws, and the recommendation need not be transmitted to the Board of Trustees until after the applicant has exercised or waived such rights.

2.10.4.7 BOARD OF TRUSTEES ACTION

Unless subject to the provisions of the fair hearing and appeal provisions in these Bylaws, the Board of Trustees shall act on the application at its next regular meeting following receipt of the recommendation from the Medical Executive Committee.

2.10.4.7.1 If the Board of Trustees adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital.

2.10.4.7.2 If the Board of Trustees does not adopt the recommendation of the Medical Executive Committee, the Board of Trustees may either refer the matter back to the Medical Executive Committee with instructions for further review and recommendation and a time frame for responding to the Board of Trustees, or the Board of Trustees may take unilateral action. If the matter is referred back to the Medical Executive Committee, the Medical Executive Committee shall review the matter and shall forward its recommendation to the Board of Trustees within 30 days of receipt of the referral from the Board of Trustees. If the Board of Trustees adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital.

2.10.4.7.3 If the action of the Board of Trustees is adverse to the applicant, the Secretary of the Board of Trustees shall promptly send written notice to the applicant. Such notice shall contain the information prescribed in the Article Six of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in the Article Six of these Bylaws, and the adverse decision of the Board of Trustees shall not become final until after the applicant has exercised or waived such rights. At its next regular meeting, after all of the applicant's hearing and appeal rights under these Bylaws have been exhausted or waived, the Board of Trustees shall take final action.

2.10.4.7.4 All decisions to appoint shall include a delineation of clinical privileges when clinical privileges are being requested, the assignment of a Medical Staff category and Department affiliation, and any applicable conditions placed on the appointment or clinical privileges. The applicant shall be so notified.

2.10.5 Subject to any applicable provisions of Article Six, notice of the Board of Trustees' final decision shall be given in writing through the Secretary of the Board of Trustees to the applicant within five (5) working days of the final decision. In the event a hearing and/or appeal was held, Article Six shall govern notice of the Board of Trustee' final decision.

2.11 CREDENTIALS SUBJECT TO ONGOING VERIFICATION

In addition to being verified at the time of initial appointment and initial granting of privileges, and at reappointment or renewal or revision of clinical privileges, the following credentials shall be subject to primary source verification, at the time of expiration and renewal or as specified. Any failure to continuously maintain the following credentials during the entire term of appointment shall result in automatic suspension as provided in these Bylaws and shall be reported to the Credentials Committee:

2.11.1 Current licensure;

2.11.2 Drug Enforcement Administration registration;

2.11.3 Professional liability insurance;

2.11.4 Privilege-specific requirements for current certifications as applicable to the clinical privileges granted; and,

2.11.5 Eligibility to participate in the Federal Health Care Programs. The OIG Sanction Report, the GSA List and the State Exclusion List as applicable shall be checked according to the frequencies defined by Hospital policy.

2.12 ELIGIBILITY FOR COMPLETING A RECREDENTIALING REQUEST FOR CONSIDERATION (RRFC)

To be eligible to complete a Recredentialing Request for Consideration (RRFC) or apply for reappointment and renewal of clinical privileges, an individual must satisfy the Threshold Eligibility Criteria defined in these Bylaws, and during the previous appointment term shall have:

2.12.1 Completed all medical records;

2.12.2 Completed all continuing medical education requirements;

2.12.3 Satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

2.12.4 Continued to meet all qualifications and eligibility criteria for appointment and the clinical privileges requested; and,

2.12.5 For individuals requesting clinical privileges, the individual had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital, defined as less than 25 patient encounters must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization) before the RRFC shall be considered complete and processed further.

2.13 EXPIRATION OF CURRENT APPOINTMENT

2.13.1 If a complete RRFC is not submitted timely, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Only after a complete application is received by the Hospital from the CPC shall an individual be considered for reappointment or renewal of clinical privileges.

2.13.2 If a complete application for reappointment is submitted timely, but the Board of Trustees has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the current term of appointment while the application for reappointment and/or renewal of clinical privileges continues to be processed and reviewed. The Board of Trustees may subsequently grant reappointment and renewal of clinical privileges on a go forward basis.

2.14 ASSISTANCE WITH EVALUATION

The Board of Trustees, the Medical Executive Committee, the Chief Executive Officer, or any committee authorized to review or evaluate applications for Medical Staff membership or clinical privileges, or conduct ongoing review or evaluation of performance of those who currently hold Medical Staff membership or clinical privileges, may as part of these duties:

2.14.1 Obtain the assistance of an independent consultant or others to evaluate the Practitioner being subject to review;

2.14.2 Request access to and consider the results of performance improvement or quality assessment activities of other hospitals or health care institutions with respect to the Practitioner under evaluation;

2.14.3 Request or require the Practitioner under evaluation to submit to interviews with consultants who may be retained to assist in the review or evaluation process;

2.14.4 Subject to Federal or State regulations, request that specific patient records or categories of records of patients treated by the Practitioner under evaluation be submitted for review, subject to appropriate protection of patient confidentiality; and,

2.14.5 Require detailed statements, data and information concerning matters that may impact the qualifications, professional competence or conduct of the Practitioner under evaluation, including information concerning threatened or pending legal or administrative proceedings.

3 ARTICLE THREE: CATEGORIES OF THE MEDICAL STAFF

CATEGORIES

The Medical Staff shall include the membership categories of Active Staff, Affiliate Staff, and Ambulatory Staff. At the time of appointment and at the time of each reappointment, the Medical Staff Member's membership category shall be recommended by the Medical Executive Committee and approved by the Board of Trustees.

3.1 LIMITATIONS ON PREROGATIVES

The prerogatives of Medical Staff membership in these Bylaws are general in nature and may be limited or restricted by special conditions attached to a Practitioner's appointment or reappointment, by state or Federal law or regulations, or other provisions of these Bylaws, the Rules and Regulations, or other policies, commitments, contracts or agreements of the Hospital.

3.2 ACTIVE STAFF

3.2.1 REQUIREMENTS FOR ACTIVE STAFF

The Active Staff membership category shall consist of Practitioners who actively support the Medical Staff and the Hospital by contributing to efforts to fulfill Medical Staff functions. The Active Staff category of Practitioners shall be responsible for oversight of care, treatment and services provided by the Medical Staff, and members in the Active Staff category shall have the requisite skills for providing such oversight. To qualify for the Active Staff category, the Medical Staff Member shall have contributed to fulfilling Medical Staff functions by completing at least two of the following types of activities during the last term of appointment, as determined by the Department Chairperson and approved by the Board of Trustees, including following initial appointment:

- Term of office as a Medical Staff Officer or Department Chairperson;
- Membership on the Board of Trustees;
- Medical Staff committee Chairperson;
- Medical Staff committee Member;
- Attend 2 meetings per year to include: committee meetings, department meetings or general medical staff meetings

- Timely response to on-call duties when on-call;
- Serving as a proctor to a Practitioner under focused professional practice evaluation;
- Serving as a physician advisor or peer reviewer;
- Timely completion of medical records (e.g., Member had patient admissions and had no delinquencies in completion of their records during term of appointment);
- Serving on a Hospital committee or team/task group;
- Supervisory duties, e.g., serving as the medical director of a Hospital department, or supervision of a Limited Licensure Practitioner;
- Providing education to fellow Medical Staff members, e.g., grand rounds, formal educational presentation, author of a Medical Staff newsletter article; or,
- Supervising participants in a Hospital-sponsored professional graduate education program.

3.2.2 PREROGATIVES OF ACTIVE STAFF

Members of the Active Staff shall be eligible to vote and hold office within the Medical Staff organization. Any Active Staff Member may attend Medical Staff and Department meetings and serve on committees of the Board of Trustees, Medical Staff or Hospital. Members in the Active Staff category shall compose the group defined as the Organized Medical Staff.

3.2.3 OBLIGATIONS OF ACTIVE STAFF

Each Member of the Active Staff shall discharge the basic obligations of Medical Staff members as required in these Bylaws and any future changes to these Bylaws; accept emergency on-call coverage for emergency care services within his/her Medical Staff Department or Division as specified by the requirements of the assigned Medical Staff Department; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; actively participate in the quality assessment and performance improvement activities of the Hospital; attend Medical Staff and Department meetings; and perform such further duties as may be required of him/her under these Bylaws, or Rules and Regulations, or Policies including any future changes to these Bylaws, or Rules and Regulations, or Policies, and comply with directives issued by the Medical Executive Committee.

3.3 **AFFILIATE STAFF**

3.3.1 REQUIREMENTS FOR AFFILIATE STAFF

The Affiliate Staff membership category shall consist of Practitioners who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty, or other reasons, but who wish to remain affiliated with the Hospital for consultation, call coverage, referral of patients, or other patient care purposes.

3.1.2 PREROGATIVES OF AFFILIATE STAFF

Members of the Affiliate Staff shall not be eligible to vote or hold office within the Medical Staff organization. An Affiliate Staff Member may serve on committees of the Medical Staff or

Hospital and may attend Medical Staff and Department meetings. Affiliate Staff members completing at least two of the activities required for Active Staff during a current term of appointment may request advancement to the Active Staff category. An Affiliate Staff Member will be limited to fifty (50) patient contacts in any appointment period. If contact requirements are exceeded, reappointment will be to the Active Staff. (A "contact" is any admission, consultation, operation, emergency room visit or procedure on an inpatient or outpatient basis except that no more than one "contact" will be considered for any patient for whom the Affiliate Member is the admitting or consulting physician.

3.1.3 OBLIGATIONS OF AFFILIATE STAFF

Each Member of the Affiliate Staff shall discharge the basic obligations of Medical Staff members as required in these Bylaws and any future changes to these Bylaws; accept emergency on-call coverage for emergency care services within his/her clinical specialty as may be specified by the requirements of the assigned Medical Staff Department; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; and perform such further duties as may be required of him/her under these Bylaws, or Rules and Regulations, or Policies.

3.4 AMBULATORY STAFF

3.4.1 REQUIREMENTS FOR AMBULATORY STAFF

The Ambulatory Staff membership category shall consist of Practitioners who do not practice in the Hospital but still desire to maintain Medical Staff appointment to provide continuity of care to their patients or to satisfy a criterion of Medical Staff membership and access to in-network hospital services that may be required for participation in managed care organization panel(s). The Ambulatory Staff category is a membership-only category of the Medical Staff with no clinical privileges, and limited Medical Staff responsibilities and prerogatives. As Members of the Medical Staff, Ambulatory Staff shall be fully credentialed and shall be granted membership based on a recommendation by the Medical Staff, with approval by the Governing Body. Since no clinical privileges are granted, Ambulatory Staff shall not be subject to the requirements for focused professional practice evaluation or ongoing professional practice evaluation.

3.4.2 PREROGATIVES OF AMBULATORY STAFF

Members of the Ambulatory Staff may visit their hospitalized patients, and review their patients' medical records, but they exercise no clinical privileges and may not write orders, progress notes, or other notations in the medical record, provide any patient care, or perform any procedures. Ambulatory Staff shall not be eligible to vote or hold office within the Medical Staff organization.

3.4.3 OBLIGATIONS OF AMBULATORY STAFF

Each Member of the Ambulatory Staff shall discharge the basic obligations of staff members as required in these Bylaws and any future changes to these Bylaws; but they shall not provide emergency on-call coverage or perform any other duties for which clinical privileges are required. Each Member of the Ambulatory Staff shall establish appropriate referral and coverage arrangements with an Active or Affiliate Staff Member for the medical care of his/her patients that require Hospital services.

3.5 HONORARY RECOGNITION

3.5.1 REQUIREMENTS FOR HONORARY RECOGNITION

Honorary Recognition shall be granted to Practitioners retired from professional practice who are recognized for their noteworthy contributions to the health and medical sciences, or previous long-standing service to the Hospital. Due to being retired, Practitioners with Honorary Recognition are not eligible for Medical Staff membership or clinical privileges, and therefore shall not be subject to any credentialing or clinical privileging process, shall not be subject to FPPE or OPPE requirements, and shall not have any prerogatives or obligations associated with Medical Staff membership.

3.5.2 PREROGATIVES OF HONORARY RECOGNITION

Practitioners with Honorary Recognition shall be invited and welcome to attend educational and social functions of the Hospital and Medical Staff.

3.6 CHANGE IN STAFF CATEGORY

Pursuant to a request by the Medical Staff Member, upon a recommendation by the Credentials Committee, or pursuant to its own action, the Medical Executive Committee may recommend a change in Medical Staff category of a Member consistent with the requirements of the Bylaws. The Board of Trustees shall approve any change in category.

3.7 ADVANCED PRACTICE PROFESSIONALS

The term, "Advanced Practice Professional" (APP) refers to individuals, other than those defined as a Practitioner, who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. Categories/types of APPs eligible for clinical privileges shall be approved by the Board of Trustees and shall be credentialed through the same processes as a Medical Staff Member, as described in Article Two, and shall be granted clinical privileges as either a dependent or independent healthcare professional as defined State laws and in these Bylaws. Although APPs are credentialed as provided in these Bylaws, in Article Two, they are not eligible for Medical Staff membership. They may provide patient care services only as permitted by state laws and to the extent of the clinical privileges that have been granted. The Board of Trustees has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetist, certified nurse midwives, advanced practice registered nurse practitioner and clinical psychologist.

A Medical Staff Member who fails to fulfill the responsibilities as outlined in the Rules and Regulations and/or in a sponsorship agreement for the supervision of an APP or a dependent healthcare professional shall be subject to appropriate actions provided by these Bylaws.

3.7.1 REQUIREMENTS FOR ADVANCED PRACTICE PROFESSIONALS

As permitted by state law, APPs shall be responsible and accountable at all times to a Member of the Medical Staff, and shall be under the supervision and direction of a Member of the Medical Staff. The terms of the accountability of the APP to the Medical Staff Member and the terms for supervision of the APP by a Medical Staff Member shall be documented in a sponsorship agreement between the APP and the sponsoring Medical Staff Member. In addition to a complete application, as defined in these Bylaws, a sponsorship agreement shall be on file at the Hospital. The sponsorship agreement and requests for clinical privileges shall contain all of the following information:

3.7.1.1.1 Name of the sponsoring Medical Staff Member and name of any alternative sponsoring Medical Staff members;

3.7.1.1.2 Completed sponsoring Medical Staff Member's evaluation;

3.7.1.1.3 Requested clinical privileges shall specify the degree of supervision required for the performance of each clinical privilege, and shall be signed by the sponsoring Medical Staff Member(s);

3.7.1.1.4 Signed agreement by the sponsoring Medical Staff Member(s) to provide required supervision and accept responsibility for the patient care services provided by the APP.

3.7.2 PREROGATIVES OF ADVANCED PRACTICE PROFESSIONALS

APPs shall not be eligible to vote, or hold office within the Medical Staff organization. An APP may attend Medical Staff or Department/Division meetings if invited. An APP may admit patients to the Hospital only if eligible for admitting privileges if allowed by State laws, and only if granted admitting privileges by the Board of Trustees. Patients admitted by an APP shall be under the care of a physician.

3.7.3 OBLIGATIONS OF ADVANCED PRACTICE PROFESSIONALS

Each APP shall discharge the basic obligations of members as required in these Bylaws; abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital, as applicable to his/her activities in association with the Hospital.

4 ARTICLE FOUR: CLINICAL PRIVILEGES

4.1 EXERCISE OF PRIVILEGES

Every Practitioner or Advanced Practice Professional providing direct clinical services at this Hospital, by virtue of Medical Staff membership or otherwise, shall, in connection with such practice and except as provided in Sections 4.4 and 4.5 below, be entitled to exercise only those clinical privileges specifically granted to him/her by the Board of Trustees. The privileges must be Hospital-specific, within the scope of the license authorizing the individual to practice in this State or any certificate or other legal credential authorizing practice in this State and consistent with any restrictions thereon, within the scope of the individual's current competence, and shall be subject to the Rules and Regulations of the Department or Division. Clinical privileges may be granted, continued, modified, or terminated by the Board of Trustees upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outlined in these Bylaws. Each Practitioner must obtain consultation with another Practitioner who possesses appropriate clinical privileges in any case when the clinical needs of the patient exceed the clinical privileges of the Practitioner(s) currently attending the patient. Additionally, consultation must be obtained when required by these Bylaws, the Medical Staff and Department/Division Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation.

4.2 QUALIFICATIONS FOR PRIVILEGES

4.2.1 Requests for clinical privileges shall be processed pursuant to the procedures outlined in Article Two of these Bylaws. Clinical privileges shall be delineated on an individual basis. In evaluating an applicant who requests renewal or revision of clinical privileges, the evaluation shall include ensuring that the applicant does not practice outside the scope of privileges granted, and information about the applicant's change in scope of practice shall be reflected when updated privilege delineation is made, and only approved privileges that are within the scope of practice shall be permitted. The delineation of an individual's privileges shall include the limitations, if

any, on the individual's privileges to admit or treat patients or direct the course of treatment of the patients who have been admitted.

4.2.2 There shall be criteria for granting, renewing or revising clinical privileges that are directly related to the quality of healthcare and pertain to the evidence of current competence and ability to perform the privileges requested. Applications and requests for clinical privileges shall be evaluated on the basis of the applicant's education, training, current competence, the ability to perform the clinical privileges requested, professional references and peer recommendations that include written information about the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and health status as related to ability to perform the privileges requested, information from the applicant's current or past facility affiliations regarding membership status and current competence, professional liability experience and insurance coverage, and other relevant information, including an evaluation by the Chairperson of the Clinical Department in which the privileges have been sought. The criteria for granting clinical privileges shall also include the ability of the Hospital to provide supportive services for the applicant and his/her patients. Clinical privileges that are granted, renewed, or revised shall be appropriate to the scope of services and service capabilities of the Hospital, meaning that in approving privileges, considerations shall include not only the applicant's qualifications but also the availability of equipment, the number, type and qualifications of staff, and/or the appropriateness of the physical environment and resources in a particular Hospital setting, and clinical privileges may be restricted by the Board of Trustees to only certain settings within the Hospital, as appropriate to each setting.

4.2.3 The basis for privilege determinations for continuation of privileges shall include, in addition to the above listed information, the results of ongoing professional practice evaluation, as provided for in the Medical Staff's Professional Practice Evaluation Policy. Additionally, all individuals with delineated clinical privileges are required to participate in continuing education as related to their privileges, and the applicant's participation in continuing education shall be considered when renewing or revising such privileges. Before clinical privileges are granted, renewed, or revised by the Board of Trustees, the Medical Staff shall evaluate each applicant with regard to the following information and make a recommendation based on the following information:

4.2.3.1 For applicants in fields performing operative and other procedures, the types of operative procedures performed as the surgeon of record, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information about compliance with accepted performance standards and outcomes of the procedures;

4.2.3.2 For applicants in non-surgical fields, the types and outcomes of medical conditions managed by the applicant as the responsible physician;

4.2.3.3 The applicant's clinical judgment and technical skills;

4.2.3.4 Any evidence of unusual patterns of, or an excessive number of, professional liability claims or legal actions resulting in voluntary settlement(s) or final judgment(s) against the applicant;

4.2.3.5 Information from quality assessment and performance improvement, including but not limited to review of operative and other procedures, use of blood and blood products, use of medications, review of medical records, utilization management/medical necessity review, risk management data, and patient safety data;

4.2.3.6 Relevant Practitioner-specific data that are compared to aggregate data available from specialty specific organizations such as the Society of Thoracic Surgeons (STS) or the American College of Cardiology (ACC);

4.2.3.7 Morbidity and mortality data, when available;

4.2.3.8 Practitioner's use of consultants;

4.2.3.9 Practitioner's performance relative to approved standards of practice, patient care protocols, and evidence-based clinical practice guidelines, including but not limited to compliance with core measures protocols.

4.2.4 The information used in the ongoing professional practice evaluation may be acquired through periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussion with other individuals involved in the care of each patient including the consulting physicians, assistants at surgery, nursing and administrative personnel. Additionally, in considering any request to grant, continue, modify, or increase clinical privileges, the Hospital, including any committee of the Medical Staff, or the Board of Trustees may, in its discretion, obtain assistance with their evaluation, as provided for in Article Two of these Bylaws.

4.2.5 REQUEST FOR PRIVILEGES

4.2.5.1 Clinical privileges may be granted only upon formal request on forms prepared and provided by the Hospital with subsequent processing and approval. Unless an individual is requesting Medical Staff membership only, every RFC or RRFC must contain a request for the specific clinical privileges desired by the individual if clinical privileges are being requested. A request for clinical privileges without a request for Medical Staff membership shall contain the same information as an application for Medical Staff membership. An individual requesting clinical privileges shall be subject to the same obligations as are imposed upon an applicant for Medical Staff appointment, as provided in these Bylaws. Only those clinical privileges supported by evidence of competence and proof that the applicant meets the criteria for each privilege will be processed through the application process. Pursuant to these Bylaws, the responsibility for producing a complete application and request for clinical privileges shall be the applicant's.

4.2.5.2 Admitting Privileges: Only Medical Staff members with clinical privileges or qualified Practitioners granted temporary privileges may be granted admitting privileges. The privilege to admit shall be delineated, and is not automatic.

4.2.5.3 Medical History and Physical Examination Requirements: Clinical privileges for performing a medical history and physical examination shall be delineated. The medical history and physical examination shall be completed and documented by a qualified Physician, a qualified Oromaxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy. A medical history and physical examination shall be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but always prior to surgery or a procedure requiring anesthesia services. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a Qualified Physician, a Qualified Oromaxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy. Refer to the Medical Staff Rules & Regulations for complete information on Medical History and Physical Examination Requirements.

4.2.6 ADDITIONS TO OR INCREASES IN CLINICAL PRIVILEGES

4.2.6.1 Determination of a change in clinical privileges shall be based on a Practitioner's subsequent training, experience, and demonstrated competence. A review of each Practitioner's documented professional training and focused professional practice evaluation will be included in the review of such Practitioner's request for a change in privileges. A Practitioner who desires a change in his or her clinical privileges in any department shall make a written request to the Chief Executive Officer. The CPC will process the request by performing verifications of training and/or experience and other queries as outlined in this Section 4.2.6. The Chief Executive Officer will then submit the Practitioner's written request and any related information to the Chairperson of the appropriate department for recommendation. The request and the recommendation of the Chairperson of the appropriate department will then be forwarded to the Credentials Committee. The Credentials Committee shall consider the request and will then report recommendations to the Medical Executive Committee. The written comments of the Medical Executive Committee, if any, will be forwarded to the Board of Trustees. Should the Credentials Committee or the Medical Executive Committee make a proposed recommendation against the requested change, the proposed recommendation will be forwarded to the Chief Executive Officer who will notify the Practitioner of the proposed adverse recommendation and of the right to a hearing in accordance with the Fair Hearing Procedure. Such notification will be made prior to forwarding the proposed adverse recommendation to the Board of Trustees. No Practitioner may seek clinical privileges previously requested and denied unless supported by additional training and/or experience.

4.2.6.2 A request by an individual with membership or clinical privileges for additional clinical privileges or an increase in clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. The following documentation shall be included with any requests for an increase in clinical privileges and new clinical privileges:

4.2.6.2.1 Any additional license, certification or registration required for the new clinical privileges or increased clinical privileges requested shall be disclosed by the applicant and verified.

4.2.6.2.2 Training, continuing education, and experience related to the new clinical privileges or increased clinical privileges requested shall be disclosed by the applicant and verified.

4.2.6.2.3 Evidence of current competence related to the new clinical privileges or increased clinical privileges requested shall be verified. This shall include a review of relevant Practitioner-specific performance data when available.

4.2.6.2.4 An evaluation provided by peer(s) of the applicant shall be included in the information considered after a request to add or increase clinical privileges. The peer evaluation shall be in writing and address medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

4.2.6.2.5 Applicants are required to report and confirm malpractice insurance coverage information for the new privileges or increased clinical privileges requested. Claims history shall be evaluated to determine any evidence of an unusual pattern or excessive number of claims.

4.2.6.2.6 The Hospital shall query the National Practitioner Data Bank (NPDB) when new clinical privileges or increased clinical privileges are requested.

4.2.6.2.7 When adding or increasing clinical privileges the applicant shall be required to attest to his/her health status as related to ability to perform the new or increased clinical privileges being requested and health status shall be verified.

4.2.6.3 When adding or increasing clinical privileges the applicant shall be required to respond to queries regarding whether there have been any:

4.2.6.3.1 Previously successful or currently pending challenges to licensure or registration, or voluntary or involuntary relinquishment of licensure or registration.

4.2.6.3.2 Voluntary or involuntary reduction in privileges or termination of privileges or membership.

4.2.6.3.3 Involvement in any liability actions, including any final judgments or settlements.

4.2.7 LOCUM TENENS PRIVILEGES

Clinical privileges may be granted to a Practitioner qualified as described in Article Two, who plans to practice within the Hospital on an intermittent or substitute basis. Unless requested, a locum tenens Practitioner shall not be granted Medical Staff membership. The locum tenens Practitioner shall be credentialed as described in Article Two, and if qualified may be granted requested delineated clinical privileges for a period limited to the time during which the Practitioner is serving as a substitute for a Medical Staff Member, or for the time of intermittent coverage, but in no case shall the term of privileges be greater than two years from the date the clinical privileges were approved. The locum tenens Practitioner may be eligible for temporary privileges in accordance with Article Four of these Bylaws if requesting privileges to provide care, treatment, or services in response to an immediate important patient care need, or after submitting a complete application with no adverse information while the application that was approved by the Department Chairperson and the Credentials Committee awaits approval by the Medical Executive Committee and the Board of Trustees. The locum tenens Practitioner shall be subject to the Medical Staff Bylaws, Rules & Regulations, and policies, including requirements for focused professional practice evaluation and ongoing professional practice evaluation, and rights to a fair hearing.

4.2.8 PRIVILEGES TO SUPPORT POST-RESIDENCY/FELLOWSHIP SURGICAL TRAINING

To support the introduction of a new procedure or new technology at the Hospital, the Board of Trustees shall determine the appropriateness of the Hospital as a training site, based on whether the Hospital has the resources necessary to support a request to conduct training, such as sufficient space, equipment, staffing, and financial resources, and whether the new procedure or new technology or the offer of training for the procedure/technology fits within the Hospital's operational planning and is appropriate for the Hospital's patient population. Training shall not be conducted until first approved by the Board of Trustees based on a recommendation from the Medical Executive Committee. The preceptor/trainer and the preceptee/trainee shall be credentialed as described in Article Two of these Bylaws to verify the qualifications necessary for these roles. Clinical privileges shall be specifically delineated for the role, in which the individual shall serve, and the new procedure or new technology to be taught. The preceptor/trainer and the preceptee/trainee shall be subject to the Medical Staff Bylaws, Rules & Regulations, and policies, specifically including any relevant requirements related to patient rights, informed consent, and if applicable, requirements related to the

conduct of research. After completion of training, the preceptee/trainee may be eligible to request clinical privileges for the new procedure or new technology, provided that competency in the privilege has been validated. For purposes of this Section, the following definitions shall apply:

4.2.8.1 Preceptor/trainer: An expert surgeon/physician who undertakes to impart his or her clinical knowledge and skills in a defined setting to a preceptee. The preceptor must be appropriately privileged, skilled, and experienced in the procedure(s) and or technique(s) in question. To serve as a preceptor in a specific procedure or technique, the surgeon/physician (preceptor) must be a recognized authority (e.g., through publications, presentations, extensive clinical experience) in the particular field of expertise.

4.2.8.2 Preceptee/trainee: A surgeon/physician with appropriate basic knowledge and experience seeking individual training in skills and/or procedures not learned in prior formal training. The trainee must have appropriate background knowledge, basic skills, and clinical experience relevant to the proposed curriculum. The trainee should be board-eligible as defined in these Bylaws or certified in the appropriate specialty or possess equivalent board certification from outside the United States.

4.2.9 NEW OR TRANSPECIALTY PRIVILEGES

Prior to accepting a request for a specific privilege, the resources necessary to support the privilege shall be determined to be currently available, or available within a specified time frame. Hospital leaders shall determine whether sufficient space, equipment, staffing, and financial resources are in place or will be available within a specified time frame to support each privilege. The clinical privileges available for request shall be approved by the Board of Trustees, based on this determination of hospital leaders. Any request for clinical privileges that are either new to the Hospital or that overlaps more than one Department shall initially be reviewed by the Credentials Committee. The Credentials Committee shall facilitate the establishment of hospital-wide credentialing criteria for the new or transpecialty procedure, with the input of all appropriate Departments, with a mechanism designed to ensure that the same level of quality of patient care is provided by all individuals with such clinical privilege. In establishing the criteria for such clinical privileges, the Credentials Committee may establish an ad-hoc committee with representation from all appropriate Departments or the committee members may undertake the process themselves. Information may be requested from one or more Practitioners or Departments, or from outside sources such as professional literature or specialty associations. In addition to establishing privileging criteria, the Credentials Committee may consider the need for development of policies related to call coverage, cross coverage, manner of handling clinical complications, and any other clinical policies that may be needed in association with new or transpecialty privileges. The recommendation of the Credentials Committee shall be forwarded to the Medical Executive Committee for its review. The recommendation of the Medical Executive Committee and the approval of the Board of Trustees shall be based in part on whether the new procedure or service is appropriate to the Hospital.

4.2.10 DISCONTINUING A SERVICE

As part of the process for ongoing evaluation and planning of patient care services, the Board of Trustees may determine that a particular patient care service shall be discontinued. In the event that a patient care service is discontinued the Board of Trustees shall retract the clinical privileges associated with the provision of those services and notify the affected Practitioners and APPs of the clinical privileges that have been retracted as of a specified effective date. Clinical privileges shall be retracted due to changes in the services provided by the Hospital, and retraction of clinical privileges shall not be considered an adverse action, therefore, there

shall be no right to hearing and appeal in association with decisions to change the services offered by the Hospital

4.2.11 CONTRACTS FOR SERVICES

From time to time, the Hospital may enter into contracts with Practitioners and/or groups of Practitioners for the performance of clinical and administrative services at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of these Bylaws.

4.2.11.1 To the extent that:

4.2.11.1.1 any such contract confers the exclusive right to perform specified services to one or more Practitioners or groups of Practitioners, or

4.2.11.1.2 the Board of Trustees by resolution limits the Practitioners who may exercise privileges in any specialty to employees of the Hospital or its affiliates,

no other Practitioner except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized Practitioners are eligible to apply for appointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

4.2.11.2 If any such exclusive contract or resolution would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and review procedures:

4.2.11.2.1 The affected member shall be given at least 30 days' advance notice of the exclusive contract or Board of Trustees resolution and have the right to meet with the Board of Trustees or a committee designated by the Board of Trustees to discuss the matter prior to the contract in question being signed by the Hospital or the Board of Trustees resolution becoming effective.

4.2.11.2.2 At the meeting, the affected member shall be entitled to present any information that he or she deems relevant to the decision to enter into the exclusive contract or enact the Board of Trustees resolution.

4.2.11.2.3 If, following this meeting, the Board of Trustees confirms its initial determination to enter into the exclusive contract or enact the Board of Trustees resolution, the affected member shall be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board of Trustees resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board of Trustees resolution and continues for as long as the contract or Board of Trustees resolution is in effect.

4.2.11.2.4 The affected member shall not be entitled to any procedural rights beyond those outlined above with respect to the Board of Trustees' decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article Six of these Bylaws.

4.2.11.2.5 The inability of a Practitioner to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the State licensure board or to the National Practitioner Data Bank.

4.2.11.3 Except as provided in Section 4.2.11.1, in the event of any conflict between these Bylaws and the terms of any contract, the terms of the contract shall control.

4.2.12 TELEMEDICINE PRIVILEGES

Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff Member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws. The Medical Staff shall define in the Rules and Regulations or Medical Staff policy which clinical services are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards. Consideration of appropriate utilization of telemedicine equipment by the telemedicine Practitioner shall be encompassed in clinical privileging decisions. In addition to meeting all other qualifications for clinical privileges, the following credentialing procedures shall be followed:

4.2.12.1 When a telemedicine provider is providing services from a different State, licensure and/or other requirements that may be imposed by a State will be verified for both the State where the Hospital is located and the State where the Practitioner is located.

4.2.12.2 Specific to telemedicine providers, due to extraordinary high number of healthcare affiliations, queries will be limited to the top five high volume affiliations and any healthcare organization from which the Practitioner was reassigned during the last five years.

4.2.13 USE OF OUTPATIENT ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS AND APPS

4.2.13.1 Non-privileged Practitioners and non-privileged APPs may refer patients and order outpatient ancillary services. Only if the Practitioner or APP is:

4.2.13.1.1 Responsible for the care of the patient;

4.2.13.1.2 Licensed in, or holds a license recognized in the jurisdiction where he/she sees the patient;

4.2.13.1.3 Acts within his/her scope of practice under State law;

4.2.13.1.4 Is not an ineligible person; and,

4.2.13.1.5 Is authorized by the Medical Staff to order the applicable outpatient services under written Hospital policy that is approved by the Board of Trustees of the Hospital.

4.2.13.2 Out-of-state non-privileged Practitioners and non-privileged APPs may be allowed to refer patients and order outpatient ancillary services without having a license to practice in the State in which the Hospital is located provided the State's professional licensure agency allows an exception.

4.2.13.3 A non-privileged Practitioner's and non-privileged APP's ordering practices shall be subject to the supervision of the Medical Staff. If there is information that indicates the requirements for a non-privileged Practitioner or non-privileged APP to order patient care have not been satisfied, or if the order lacks evidence of medical appropriateness, the order shall not be performed and the non-privileged Practitioner or non-privileged APP shall be notified immediately to be given the opportunity to clarify the information or justify the order. The patient will be informed of the reasons why the test cannot be performed and instructed to call his/her Practitioner. The patient may be given a Patient Information Pamphlet.

4.2.13.4 All diagnostic tests that require an interpretation by a Practitioner granted clinical privileges to do so shall be subject to interpretation by a Member of the Medical Staff with such privileges and the interpretation shall be provided in writing to the non-privileged Practitioner or non-privileged APP.

4.3 UNAVAILABLE CLINICAL PRIVILEGES

Notwithstanding any other provisions of these Bylaws, to the extent that any requested clinical privilege is not available at the Hospital, the request shall not be processed and the individual shall be informed that the privilege is not available and such refusal to process a request shall not be subject to the fair hearing rights under these Bylaws or to reporting. .

4.4 TEMPORARY CLINICAL PRIVILEGES

Temporary clinical privileges constitute temporary permission to attend patients at the Hospital. Temporary clinical privileges are distinguished from other privileges of the Hospital in that they are not based upon complete review of credentials and are granted or revoked by the Chief Executive Officer after consultation of the President of the Medical Staff or his or her designee. Temporary clinical privileges may be granted only for a specific period of time, not to exceed 120 days, and shall automatically expire at the end of the specified period, without recourse by the Practitioner under the Fair Hearing Procedure. Temporary clinical privileges shall be granted only to individuals defined as Practitioners in these Bylaws or to APPs as defined in these Bylaws, to fulfill an important patient care need that cannot be otherwise met by the existing members of the Medical Staff or currently privileged APPs. Therefore, temporary privileges shall be granted only rarely. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner or APP exercising such privileges. A Practitioner or APP shall not be entitled to the procedural rights of fair hearing or appeal afforded by these Bylaws because of his/her inability to obtain temporary privileges or because of any revocation of temporary privileges, unless the revocation is based on questions of clinical competency or professional conduct.

4.4.1 QUALIFICATIONS

Prior to temporary privileges being granted, an applicant for such privileges must demonstrate that he/she possesses a current license within this State, a current and unrestricted DEA registration reflecting an in-state address for the State of Kansas (if the Practitioner will be prescribing or administering controlled substances), evidence of ability to perform the temporary privileges requested, current competence related to the temporary privileges requested, documentation of professional liability insurance coverage as required by the Board of Trustees except as specified in Section 4.4.2.3 in this Article, and for Practitioners a signed Physician Acknowledgement Statement must be submitted prior to performing any patient care. Qualifications for temporary privileges shall be verified from a primary source or designated agent of the primary source, and documented. The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges. Additionally, the Hospital shall verify the applicant's status as an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare NPI, and the Hospital shall check the OIG Sanction Report, the GSA List, and the State Exclusion List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges without any right to the hearing and appeal procedures in Article Six of these Bylaws. When applying for temporary privileges, each applicant shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, departmental rules and regulations, and applicable Hospital policies. Individuals who are granted temporary privileges will be subject to the Hospital's policy regarding focused professional practice evaluation (FPPE). Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.4.2 CONDITIONS AND AUTHORITY FOR GRANTING TEMPORARY CLINICAL PRIVILEGES

Temporary privileges may be granted by the Chief Executive Officer upon receiving a favorable recommendation from the appropriate Department Chairperson or President of the Medical Staff under the conditions noted below. Individuals practicing based on temporary privileges shall be acting under the supervision of the Chairperson of the Department to which he/she is assigned. All temporary privileges shall be time-limited, as specified for the type of temporary privileges listed below. During the time temporary privileges are in effect, the exclusion lists shall be rechecked according to the frequencies defined by Hospital policy. Temporary privileges shall automatically terminate at the end of the specific period for which they were granted, without the Hearing and Appeal rights set forth in these Bylaws. Temporary privileges shall be specifically delineated, and may include the privilege to admit patients. A request for temporary privileges shall be made in writing, on forms approved for that purpose by the Hospital.

4.4.2.1 Pendency of Application: After receipt of complete application for Medical Staff membership, as defined in these Bylaws, which includes a written request for temporary privileges, an applicant qualified as described in Section 4.4.1 may be granted temporary privileges while his/her application undergoes processing. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days and cannot exceed the regular privileges applied for by the applicant. An applicant awaiting processing of a complete application for Medical Staff membership shall be eligible for temporary privileges only after submitting a complete application and only under the following conditions:

4.4.2.1.1 There are no current or previously successful challenges to licensure or registration;

4.4.2.1.2 There are no adverse membership actions at another hospital; and,

4.4.2.1.3 There are no adverse actions against the applicant's privileges at another hospital.

4.4.2.2 Care of Specific Patient(s): Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein. After receipt of a written request for temporary privileges, a Practitioner or APP qualified as described in Section 4.4.1 may be granted temporary privileges if the Practitioner or APP has a specific skill not possessed by a privileged Practitioner or APP, and the specific skill is needed by a specific patient or specific group of patients, authorization may be granted to provide care for that specific patient or group of patients. Temporary privileges granted under this condition shall not exceed the length of stay of the specific patient(s) or one hundred and twenty (120) consecutive days, whichever is less. A Practitioner or APP may be granted temporary privileges under this condition for no more than two instances in a twelve-month period. After a Practitioner or APP has been granted temporary privileges under this condition for the second instance within twelve months, he/she shall be required to apply for Medical Staff membership and/or clinical privileges before providing additional patient care, treatment or services at the Hospital.

4.4.2.3 Disaster Response and Recovery: Potential disaster situations shall be described in the Hospital Emergency Operations Plan and are defined as any occurrence that inflicts destruction or distress and that creates demands exceeding the capacities or capabilities of the Hospital to handle in a normal or routine way. Such occurrence may be due to a natural or a man-made disaster. Upon activation of the Hospital's Emergency Operations Plan and in a situation in which the Hospital is not able to meet

immediate patient needs, temporary disaster privileges may be granted to an appropriately qualified Practitioner as described in Section 4.4.1, based upon the needs of the Hospital to augment staffing due to the disaster situation. Privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the Hospital Emergency Operations Plan (EOP), upon recommendation by the President of the Medical Staff or the EOP designated Medical Staff Director. All decisions to grant temporary disaster privileges are at the discretion of the Hospital Emergency Incident Commander or designees, and shall be evaluated on a case-by-case basis in accordance with Hospital and patient care needs. Approvals shall be documented in writing. The President of the Medical Staff or the EOP designated Medical Staff Director shall also assign a Member of the Medical Staff to responsibilities for supervising Practitioners granted temporary disaster privileges, through direct observation, mentoring, or clinical record review. Practitioners who are employees of any Federal agency, and Practitioners acting on behalf of a Federal agency in an official capacity, temporarily or permanently in the service of the United States government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are therefore exempt from the requirement to have professional liability insurance coverage. Temporary privileges granted to Practitioners who are acting as agents of the Federal government shall be limited in their privileges at this Hospital to the scope of their Federal employment. Temporary privileges granted to anyone under a disaster situation shall not exceed the disaster response and recover period or one hundred and twenty (120) consecutive days, whichever is less. In the event that the disaster creates extreme urgencies as defined in Section 4.5, a Practitioner could be permitted to provide patient care using emergency privileges.

4.4.2.3.1 Temporary disaster privileges may be granted to a volunteer LIP or APP meeting the qualifications required in Section 4.4.1 of this Article which shall be verified as soon as the immediate disaster situation permits the verifications to be performed, using a process identical to granting temporary privileges for an immediate patient care need, and verification shall be completed within 72 hours from the time the volunteer Practitioner presents to the organization, or as soon as possible in an extraordinary situation that prevents verifications within 72 hours.

4.4.2.3.2 Before a volunteer LIP or APP is considered eligible to function as a volunteer, the hospital shall obtain his or her valid government-issued photo identification (for example, driver's license or passport) and at least one of the following:

4.4.2.3.2.1 A current photo identification card from a healthcare organization with a legible photo and that clearly identifies professional designation;

4.4.2.3.2.2 A current license to practice in the State of Kansas;

4.4.2.3.2.3 Primary source verification of the license;

4.4.2.3.2.4 Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or group;

4.4.2.3.2.5 Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity; or,

4.4.2.3.2.6 Confirmation by a Licensed Independent Practitioner currently privileged by the hospital or by a Medical Staff member with personal knowledge of the volunteer Practitioner's ability to act as a Licensed Independent Practitioner during a disaster.

4.4.2.3.3 The following order of preference should be used in granting temporary disaster privileges for Practitioners or APPs:

4.4.2.3.3.1 Expert from government agencies and Medical Staff members from other HCA hospitals;

4.4.2.3.3.2 Volunteer sent from known agencies (e.g., American Red Cross);

4.4.2.3.3.3 Presentation by a current hospital or Medical Staff Member(s) with personal knowledge regarding the Practitioner's or APP's identity; or,

4.4.2.3.3.4 Volunteers from the community or surrounding areas.

4.4.2.3.4 If possible, photocopies of the above-listed credentials should be made and retained as part of a credentials file.

4.4.2.3.5 Upon approval, the Practitioner should be issued appropriate Hospital security identification as required by the Hospital, and should be assigned to a Medical Staff Member if possible, with whom to collaborate in the care of disaster victims.

4.4.2.3.6 The Medical Staff shall oversee the professional practice of volunteer Practitioners either by the direct observation or mentoring provided by the Medical Staff Member assigned to the volunteer Practitioner or when a Medical Staff Member is not available to be assigned, then by medical record review to be performed as designated by the President of the Medical Staff or MEC.

4.4.2.3.7 The Hospital shall make a decision, based on information obtained regarding the credentials and professional practice of the Practitioner, within 72 hours of the volunteer Practitioner presenting to the Hospital regarding whether to continue the disaster privileges initially granted. Continuing privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the EOP, upon recommendation by the President of the Medical Staff or the EOP designated Medical Staff Director. In the event that verification of information results in an inability to confirm the qualifications of the Practitioner, privileges should be immediately terminated. When the emergency situation no longer exists, or when Medical Staff Members can adequately provide care, temporary disaster privileges terminate.

4.4.3 DENIAL, REDUCTION OR TERMINATION OF TEMPORARY CLINICAL PRIVILEGES

4.4.3.1 The CEO may, at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, or the Department chair, deny, reduce or terminate temporary clinical privileges.

4.4.3.2 Denial, termination or reduction of temporary privileges shall not constitute grounds for a hearing, and the termination shall take effect without hearing or appeal.

4.5 EMERGENCY PRIVILEGES

In an emergency, any Practitioner, to the extent permitted by his/her license, and regardless of Medical Staff membership status, Medical Staff category or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious injury, including the loss of limb or function. When the emergency no longer exists, care of the patient shall be assigned to a Medical Staff Member with the appropriate clinical privileges to provide the care needed by the patient. If the Practitioner who provided emergency care wishes to continue to care for the patient, but does not possess the appropriate clinical privileges, the Practitioner may request such privileges if properly qualified. An emergency is a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

5 ARTICLE FIVE: INFORMAL INQUIRIES, COLLEGIAL INTERVENTIONS, INVESTIGATIONS AND CORRECTIVE ACTIONS

5.1 INFORMAL INQUIRES

Any person may provide information to the Medical Staff about the conduct, performance, or competence of a Practitioner or other individual with clinical privileges. When reliable information, including the results of quality assessment or performance improvement activities, indicates that an individual may have exhibited acts, demeanor, conduct or professional performance reasonably likely to be (1) detrimental to patient safety or to the delivery of quality of patient care within the Hospital, (2) unethical, (3) unprofessional, inappropriate, disruptive or harassing, (as defined in Medical Staff and Hospital Policies, including sexual harassment), (4) contrary to the Medical Staff Bylaws, Medical Staff Rules and Regulations, or Medical Staff Policies, or (5) below applicable professional standards, the President of the Medical Staff, appropriate Department or Committee Chairperson, or Chief Executive Officer shall make sufficient inquiry to satisfy him/herself that the concern or question raised is credible.

5.2 ANY PROFESSIONAL REVIEW BODY AS DEFINED UNDER THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986 SHALL HAVE THE POWER TO CONDUCT AN INFORMAL INQUIRY OF A PRACTITIONER AND CONDUCT A COLLEGIAL INTERVENTION COLLEGIAL INTERVENTIONS

These Bylaws encourage the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational interventions, to address issues pertaining to clinical competence or professional conduct. The goal of these collegial interventions is to prompt voluntary actions by the individual to resolve an issue that has been raised. Initial collegial interventions may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Medical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such interventions to the right to a Hearing and Appeal, and shall not require reporting to the State Board of Medical Examiners and subsequently to the NPDB, except as otherwise provided in these Bylaws. Although these Bylaws encourage the use of collegial interventions, based on the specific facts and circumstances collegial interventions are not appropriate in all cases and it may be necessary to take immediate action or bypass collegial interventions.

5.2.1.1 Collegial intervention is a part of the Hospital's professional review activities and may include, but is not limited to, the following:

5.2.1.2 Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

5.2.1.3 Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in the Medical Staff Policy regarding Professional Conduct, that may be taken to address unprofessional or inappropriate conduct;

5.2.1.4 Proctoring, monitoring, consultation, and letters of guidance;

5.2.1.5 Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms;

5.2.1.6 Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;

5.2.1.7 Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;

5.2.1.8 Suggestions or recommendations that the individual seek continuing education, consultations, or other assistance in improving performance, including behavioral contracts;

5.2.1.9 Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,

5.2.1.10 Requirements to seek assistance for a health issue, as provided in these Bylaws.

5.2.2 The relevant Medical Staff leader(s), in consultation with the Chief Executive Officer, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the MEC for further action.

5.2.3 The relevant Medical Staff leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in an individual's confidential file. The individual will have an opportunity to review the documentation and respond to it. The response will be maintained in the individual's file along with the original documentation.

5.2.4 No action taken pursuant to this Section shall constitute an investigation or a corrective action.

5.3 SUMMARY SUSPENSION OR RESTRICTION

5.3.1 INITIATION OF SUSPENSION OR RESTRICTION

5.3.1.1 Whenever there are reasonable grounds to believe that the conduct or activities of a Practitioner or other individual with clinical privileges poses a threat to the life, health or safety of any patient, employee, or other person present at the Hospital and that the failure to take prompt action may result in imminent danger to the life, health or safety of any such person, the President of the Medical Staff, the chairman of any department with respect to physicians in that department, the Executive Committee of the Medical Staff, the Chief Executive Officer and the Board of Trustees shall each have the authority to (1) suspend or restrict all or any portion of an individual's clinical privileges; and (2) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; and (3) restrict access to the Hospital by the suspended Practitioner or other suspended individual with clinical privileges.

5.3.1.2 A suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.

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

5.3.1.4 A suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer and the President of the Medical Staff, and shall remain in effect unless it is modified by the Chief Executive Officer or the Medical Executive Committee. The Department Chairperson for the Department to which a suspended or restricted Practitioner is assigned shall be responsible for arranging appropriate medical coverage for any of the Practitioner's patients hospitalized at the time of the suspension or restriction. The wishes of each patient shall be considered, when feasible, in choosing a substitute Practitioner. A suspended or restricted Practitioner's elective admissions and procedures shall be rescheduled pending reinstatement or reassigned to another Practitioner as requested by each patient.

5.3.2 MEDICAL EXECUTIVE COMMITTEE RESPONSE TO A SUSPENSION OR RESTRICTION

5.3.2.1 As soon as possible after such suspension or restriction, the Medical Executive Committee shall be convened to review the matter resulting in a suspension or restriction and consider the action taken. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than suspension or restriction to protect patients, employees and/or the orderly operation of the Hospital, depending on the circumstances.

5.3.2.2 After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Executive Committee shall determine whether to recommend that there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Executive Committee must determine whether the suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable). If the Medical Executive Committee determines that any suspension should be continued, modified or terminated, its recommendation shall be forwarded to the Board of Trustees for final action.

5.3.2.3 If the Medical Executive Committee's recommendation is not adverse to the Practitioner as defined in Article Six of these Bylaws, the Practitioner shall not be entitled to a hearing and appeal.

5.3.2.4 If the Medical Executive Committee's recommendation is adverse to the Practitioner as defined in Article Six of these Bylaws, the Practitioner shall be afforded procedural rights to an appellate review as outlined in Article Six of these Bylaws. The terms of the suspension shall remain in effect pending a decision by the Board of Trustees.

5.4 FORMAL INVESTIGATION

Requests to consider a formal investigation may be initiated by the Chief Executive Officer, the Chief Medical Officer, the President of the Medical Staff, by any other officer of the Medical Staff, by the Chairman of any department, by the Chairman of any committee of the Medical Staff, or by any member of the Board of Trustees. Any request for a formal investigation shall be in writing and shall be submitted to the Chief Executive Officer, together with detailed information concerning the specific activities or conduct which constitutes grounds for the request. The initiation of a formal investigation shall not preclude the imposition of suspension or restriction of clinical privileges under Section 5.3 of these Bylaws. A formal investigation shall be initiated only after a determination by the Medical Executive Committee or the Board of Trustees to do so. A formal investigation may be conducted by the Medical Executive Committee or an Ad Hoc Investigation Committee may be appointed by the Medical Executive Committee.

5.4.1 APPOINTMENT OF AD HOC INVESTIGATION COMMITTEE

If a determination is made to investigate formally the necessity or advisability of corrective action against a particular Practitioner, an Ad Hoc Investigation Committee may be appointed. The Ad Hoc Investigation Committee shall consist of three (3) Practitioners agreed upon by the Chief Executive Officer and the President of the Medical Staff who are not in the direct economic competition with the individual who is the subject of the investigation. In the event there are not a sufficient number of Practitioners who meet such criteria, the Chief Executive Officer may appoint physicians who are not affiliated with the Hospital who meet such criteria. An investigation by an Ad Hoc Investigation Committee shall be considered an administrative matter and not an adversarial proceeding, and the investigation need not be conducted in accordance with the formal procedures for a fair hearing pursuant to the Bylaws.

5.4.2 PROCEDURE OF AD HOC INVESTIGATION COMMITTEE

5.4.2.1 If the investigation is conducted by a group or individual other than the Ad Hoc investigation Committee, that group or individual must forward a written report of the investigation to the CEO and the Medical Executive Committee as soon as practical after the assignments to investigate has been made. The Medical Executive Committee may at any time within its discretion, and shall at the request of the Board of Trustees, terminate the investigation process and proceed with action as provided below. The investigation procedures do not constitute a hearing and need not be conducted in accordance with the formal procedures for a fair hearing pursuant to the Bylaws.

5.4.2.2 The investigation shall include:

5.4.2.2.1 Conformance to the peer review policies and procedures of the Medical Staff

5.4.2.2.2 As deemed necessary by the investigating body, a review of the medical record for specific cases, a review of aggregate performance data, a review of comparative data when available, a review of any verbal or written reports regarding any specific incidents, conduct or behavior, or any other information material to the matter being investigated;

5.4.2.2.2.1 Upon conclusion of its investigation, the Ad Hoc Investigation Committee shall submit a written report to the Chief Executive Officer and to the Medical Executive Committee. Such report shall contain a statement detailing the findings of the Ad Hoc Investigation Committee. The Medical Executive Committee shall consider the report and make a recommendation to the Board of Trustees.

5.4.3 ACTION ON AN INVESTIGATION REPORT

As soon as practicable after the conclusion of a formal investigation and any required hearing or appeal pursuant to Article Six, the Board of Trustees may:

5.4.3.1 Determine that corrective action is not warranted and dismiss the matter;

5.4.3.2 Determine that corrective action is warranted, and use one of the alternatives to corrective action, as described in Section 5.2 of these Bylaws; or,

5.4.3.3 Determine that corrective action is warranted, and recommend an adverse action, which shall entitle the individual subject to such action to the procedural rights described in Article Six.

5.5 AUTOMATIC SUSPENSION OR TERMINATION OF PRIVILEGES

If an individual fails to maintain a legal credential authorizing him/her to practice, or other qualification necessary for Medical Staff membership or clinical privileges, upon confirmation of the circumstances by the Chief Executive Officer, the individual shall be immediately and automatically suspended from practicing in the Hospital by the Chief Executive Officer, and the individual's membership may be

automatically terminated. The Chief Executive Officer shall notify the individual in writing of the automatic suspension, but the suspension is effective immediately and not subject to prior notice. The Chief Executive Officer shall also notify the President of the Medical Staff and Hospital staff members, and take necessary steps to enforce the suspension.

The following circumstances shall constitute conditions for automatic suspension, and if indicated, automatic termination:

5.5.1 LICENSURE

If an individual's license to practice is revoked, suspended, or restricted by a state licensing authority, or if an individual fails to maintain a current license in the State of Kansas, he/she shall be immediately automatically suspended from practicing in the Hospital and his/her Medical Staff membership shall be automatically terminated.

5.5.2 CONTROLLED SUBSTANCE REGISTRATION

If an individual's DEA or State controlled substance registration is revoked, suspended, or restricted, (i.e., disciplinary action is taken by the DEA or State) he/she may be automatically suspended from practicing in the Hospital. If an individual fails to maintain a current unrestricted registration, (i.e., there is a lapse in renewal or failure to request all schedules needed for the prescribing privileges granted) the individual's prescribing privileges for the schedule(s) of drugs affected by the restrictions on the DEA or State controlled substance registration shall be immediately automatically suspended.

5.5.3 LIABILITY INSURANCE

If an individual's professional liability insurance is revoked or the individual fails to maintain ongoing coverage as required in these Bylaws, he/she shall be immediately automatically suspended from practicing in the Hospital.

5.5.4 ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

The occurrence of any of the following events shall result in immediate automatic suspension from practicing in the Hospital

5.5.4.1 Becoming an Ineligible Person; or,

5.5.4.2 A criminal conviction.

5.5.5 COMPLETION OF MEDICAL RECORDS

A medical record is considered to be delinquent when it has not been completed for any reason within thirty (30) calendar days following a patient's discharge. When a Medical Staff Member or individual with clinical privileges has failed to complete a medical record and the record becomes delinquent, his/her clinical privileges shall be automatically suspended at 30 days after discharge. The suspension shall continue until all of the individual's delinquent records are completed.

5.5.6 MISREPRESENTATION

Whenever it is discovered that an individual misrepresented the facts, omitted information or provided an erroneous or incomplete answer to the questions on an RFC or RRFC for Medical Staff membership or clinical privileges or in response to questions in an interview, and the misrepresentation or omission is a material or substantive misrepresentation of the individual's qualifications, competence, or character, as determined in the sole discretion of the Medical Executive Committee or the Board of Trustees, the individual's application process for membership or privileges shall be terminated, or if the individual is already appointed or granted clinical privileges before the misrepresentation is discovered then membership and clinical privileges shall be terminated. Additionally, and subject to other provisions of these Bylaws, substantial or material misrepresentation by the individual of his or her qualifications, competence or character may be

grounds for the Board of Trustees to permanently disqualify the individual from applying for membership or clinical privileges or to set a specific time period after which the individual may reapply.

If an individual fails to report to the Hospital any restriction or condition imposed on or probation with respect to his or her license by the licensure board within thirty (30) days of the imposition of such restriction, condition or probation he/she shall be immediately automatically suspended from practicing in the Hospital and his/her Medical Staff membership shall be automatically terminated.

5.5.7 FAILURE TO PROVIDE REQUESTED INFORMATION

Failure of an individual to provide information pertaining to that individual's qualifications for Medical Staff membership or clinical privileges, or in response to a written request from the Credentials Committee, the Medical Executive Committee, the Chief Executive Officer, or any other committee authorized to request such information, within the timeframe specified in the written request, will result in the automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party.

5.6 CRIMINAL ARREST OR INDICTMENT

In the event that an individual is arrested or indicted for alleged criminal acts, an immediate inquiry into the circumstances of the arrest or indictment shall be made. The Medical Executive Committee shall review the circumstances leading to the arrest or indictment and may determine if a formal investigation, suspension or termination is warranted prior to the outcome of the legal action, and shall make a report of their findings and recommendations to the Board.

5.7 REPORTING REQUIREMENTS

In compliance with the Health Care Quality Improvement Act of 1986, the Hospital shall report to the Kansas Board of Healing Arts the following actions:

5.7.1 Any professional review action that adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days;

5.7.2 Acceptance of the surrender of clinical privileges or any restriction of such privileges by a physician or dentist:

5.7.2.1 While the physician or dentist is under investigation by the health care entity relating to possible incompetence or improper professional conduct, or

5.7.2.2 In return for not conducting such an investigation or proceeding;

5.7.3 The Hospital may report to the Kansas Board of Healing Arts the actions as described in Sections 5.7.1 and 5.7.2 with respect to other health care practitioners or any other reportable incident" as defined by KAR 28-52-4(a) and required to be reported pursuant to KSA 65-4921 et seq.

5.7.4 Pursuant to Kansas law and the Medical Center's Risk Management Plan, any practitioner with direct knowledge of an incident which may be reportable under the Kansas Risk Management statues is required to report the incident in accordance with the procedures set out in the Risk Management Plan. Such report shall be referred to the designated individuals and/or committees authorized under the Risk Management Plan to conduct an evaluation to determine "reportable incident" has occurred as defined by KAR 28-52-4. If it is determined that a "reportable incident has occurred, a report shall be submitted to the responsible practitioner's licensing authority as required by law. The finding of a "reportable incident" followed by a subsequent licensing authority report does not entitle the reported practitioner to the procedural rights descried in this Article

5.8 COVERAGE DURING SUSPENSIONS

When a suspension has been imposed, the Hospital shall arrange for coverage for alterative coverage. When the individual being suspended or restricted is a Practitioner, the President of the Medical Staff or the Chairperson of the Practitioner's Department shall arrange for alternative medical coverage of a suspended Practitioner's patients in the Hospital and for coverage of patient care subject to a restriction. The wishes of the patient shall be considered in the selection of an alternative Practitioner. When the individual being suspended or restricted is an Advanced Practice Professional, the sponsoring physician shall be responsible for arranging alternative coverage for the care normally provided by the individual.

5.9 REINSTATEMENT FOLLOWING A SUSPENSION

Requests for reinstatement will be reviewed by the relevant Department chief, the Chair of the Credentials Committee, the President of the Medical Staff, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member or other individual with clinical privileges who has been subject to suspension may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, Medical Executive Committee, and the Board of Trustees for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board of Trustees for review and recommendation.

5.10 AUTOMATIC RESIGNATION

5.10.4 RELOCATION

Unless otherwise approved by the Board of Trustees upon recommendation of the Medical Executive Committee, any Member of the Medical Staff or other individual with clinical privileges who no longer meets the geographic proximity requirements of the Medical Staff because of relocation of residence or relocation of practice shall be deemed to have automatically resigned from the Medical Staff and automatically relinquished all clinical privileges. Automatic resignation of membership and/or automatic relinquishment of clinical privileges shall not entitle the individual to a fair hearing and appeal.

5.10.2 FAILURE TO APPLY FOR REAPPOINTMENT OR RENEWAL OF PRIVILEGES

In the event that reappointment or renewal of clinical privileges has not occurred due to lack of submission of a complete application prior to the expiration of the current term of appointment or privileges, the individual shall be deemed to have automatically resigned from the Medical Staff and automatically relinquished all clinical privileges. In such case the individual shall be notified of the expiration of the term of membership and/or clinical privileges and the need to apply for reappointment and/or renewal of clinical privileges if desired. Automatic resignation of membership and/or automatic relinquishment of clinical privileges shall not entitle the individual to a fair hearing and appeal.

5.10.3 FAILURE TO BE REINSTATED FOLLOWING AUTOMATIC SUSPENSION

When an individual is automatically suspended due to failure to maintain a current license, a controlled substance registration, liability insurance, or eligibility to participate in Federal programs, or the automatic suspension is due to failure to complete medical records timely, or any other reason for automatic suspension, and the automatic suspension continues for more than 60 days without verified evidence of reinstatement of the expired credential, reinstatement as a participant in Federal programs, or completion of medical records, then the individual shall be deemed to have automatically resigned from the Medical Staff and automatically relinquished all clinical privileges, and waived any rights to the fair hearing and appeal process. The individual shall be notified of the automatic resignation and the need to submit a new application if reinstatement of membership or clinical privileges is desired.

6 ARTICLE SIX: HEARING AND APPELLATE REVIEW PROCEDURES

6.1 OVERVIEW

The fair hearing and appeal process shall be the same for applicants for Medical Staff membership and existing Medical Staff members. Professional review actions are taken when there is a reasonable belief that the action shall be in the furtherance of quality healthcare, after a reasonable effort to obtain the facts of the matter, in reasonable belief that the action is warranted by the facts, and after adequate notice and hearing procedures or other procedures that are fair to the individual are afforded to the individual subject to professional review actions. Individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members are afforded a fair hearing and appeal process but that process shall be modified. The hearing and appeal procedures for individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members is described in Section 6.8.5 of these Bylaws.

6.2 EXCEPTIONS TO HEARING AND APPEAL RIGHTS

6.2.1 COLLEGIAL INTERVENTION

An individual does not have a right to a hearing or appeal under Article Six of the Bylaws because of the initiation of an informal inquiry as described in Section 5.1, or when a collegial intervention occurs as defined in Section 5.2, or when an adverse action is recommended but not taken.

6.2.2 AVAILABILITY OF FACILITIES, EXCLUSIVE CONTRACTS, MEDICAL STAFF DEVELOPMENT PLAN

The hearing and appeal rights under these Bylaws do not apply to an individual whose application or request for extension of privileges was declined on the basis that the clinical privileges being requested are not able to be supported with available facilities or resources within the Hospital, or are not granted due to closed Medical Staff or exclusive contract or in accord with a Medical Staff development plan. The hearing and appeal rights under these Bylaws do not apply to an individual who has clinical privileges retracted or automatically terminated due to the Hospital closing or discontinuing a service, or entering into an exclusive contract.

6.2.3 MEDICO-ADMINISTRATIVE OFFICER OR OTHER CONTRACT PRACTITIONER

As specified in Section 4.2.11 of these Bylaws, the terms of any written contract between the Hospital, and a Contract Practitioner or Contractor, shall take precedence over these Bylaws as now written or hereafter amended. If the contract specifies that Medical Staff membership and clinical privileges terminate upon the expiration or termination of the contract, the contracting Practitioner shall not be entitled to the hearing and appeal procedures of Article Six of these Bylaws. The hearing and appeal rights of these Bylaws shall only apply to the extent that membership status or clinical privileges are independent of the individual's contract and are also removed or suspended as outlined in Section 6.3. The contract may include a specific provision establishing alternative procedural rights applicable to reduction, removal, or suspension of Medical Staff membership and clinical privileges.

6.2.4 AUTOMATIC SUSPENSION, TERMINATION, OR RELINQUISHMENT OF PRIVILEGES

The hearing and appeal rights under these Bylaws do not apply if an individual's Medical Staff membership or clinical privileges are automatically suspended, terminated, or voluntarily relinquished in accordance with these Bylaws.

6.2.5 REMOVAL FROM EMERGENCY CALL PANEL

Participation on the emergency on-call panel is not a benefit or privilege of Medical Staff membership, but rather is an obligation imposed at the discretion of Hospital Administration.

No hearing or appeal rights under these Bylaws are available for any action or recommendation affecting a Practitioner's emergency on-call panel obligation(s).

6.2.6 HOSPITAL POLICY DECISION

The hearing and appeal rights of these Bylaws are not available if the Hospital makes a policy decision (e.g., closing a department or service, or a physical plant change) that adversely affects the Medical Staff membership or clinical privileges of any Medical Staff Member or other individual.

6.2.7 ADMINISTRATIVE ACTIONS

A Practitioner does not have the right to a hearing in any of the following circumstances:

6.2.7.1 Change to specific Medical Staff membership prerogatives (as examples: voting privileges, eligibility for committee membership, eligibility to hold office, etc.) if the reasons are unrelated to professional competence or conduct;

6.2.7.2 Actions taken due to failure to attend meetings as required;

6.2.7.3 Denial, termination or reduction of temporary privileges;

6.2.7.4 Denial of reinstatement from a leave of absence if the reasons are unrelated to professional competence or conduct;

6.2.7.5 Voluntary surrender of membership or clinical privileges because of failure to submit a complete application for reappointment or renewal of privileges prior to the expiration of the current term of membership or clinical privileges.

6.2.7.6 Any other actions except those listed in Section 6.3.

6.3 HEARING RIGHTS

6.3.1 ADVERSE RECOMMENDATIONS OR ACTIONS

Only individuals who are subject to an adverse recommendation by the Medical Executive Committee or an adverse action by the Board of Trustees are entitled to a hearing if circumstances exist which provide a right to a hearing as described in these Bylaws the following recommendations or actions shall be deemed adverse and entitle the individual affected thereby to a hearing:

6.3.1.1 Denial of initial Medical Staff appointment;

6.3.1.2 Denial of reappointment;

6.3.1.3 Suspension of Medical Staff membership;

6.3.1.4 Revocation of Medical Staff membership;

6.3.1.5 Denial of requested clinical privileges;

6.3.1.6 Involuntary reduction in clinical privileges;

6.3.1.7 Suspension or restriction of clinical privileges that lasts more than 14 days;

6.3.1.8 Revocation of clinical privileges; or,

6.3.1.9 Withdrawal of an application for renewal of membership or clinical privileges, or surrender or restriction of clinical privileges, while under investigation for possible professional incompetence or improper professional conduct or in return for not conducting an investigation or reportable professional review action; or, Involuntary imposition of significant consultation requirements where the supervising Practitioner has the power to supervise, direct, or transfer care from the Practitioner under review (excluding monitoring incidental to focused professional practice evaluation or the granting of new privileges).

6.3.2 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom an adverse recommendation or action has been taken pursuant to Section 6.3 shall promptly be given written notice of such action by the Chief Executive Officer of the Hospital sent via certified mail, return receipt requested. Such notice shall:

6.3.2.1 State the reasons for an adverse recommendation or action, with enough specifics to allow response;

6.3.2.2 Advise the Practitioner of his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws and of this Fair Hearing Plan.

6.3.2.3 Advise the Practitioner that the Practitioner has thirty (30) days following receipt of the notice to submit a written request for a hearing.

6.3.2.4 State that failure to deliver a written request for a hearing within thirty (30) days shall constitute a waiver of rights to a hearing and to appellate review of the matter, and the recommendation for adverse action will become final upon approval by the Board of Trustees.

6.3.2.5 State a summary of the Practitioner's rights at the hearing.

6.3.2.6 State that upon receipt of his/her hearing request, the Practitioner will be notified of the date, time and place of the hearing.

6.3.3 REQUEST FOR HEARING

A Practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Section 6.3.2 to file a written request for a hearing. Such requests shall be delivered to the Chief Executive Officer either in person or by certified mail return receipt requested.

6.3.4 FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 6.3.3 waives any right to such a hearing and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

6.3.4.1 An adverse recommendation by the Medical Executive Committee shall constitute acceptance of that recommendation, which shall become effective pending the final approval of the Board of Trustees.

6.3.4.2 An adverse action by the Board of Trustees shall constitute acceptance of that action, which shall become immediately effective as the final decision by the Board of Trustees.

6.4 HEARING PREREQUISITES

6.4.1 WRITTEN NOTICE

Upon receipt of a timely request for a hearing, the Chief Executive Officer shall deliver such request to the President of the Medical Staff or to the Trustees, depending on whose recommendation or action prompted the request for hearing. At least thirty (30) days prior to the hearing, the Practitioner shall be sent a written notice stating the following:

6.4.1.1 The place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, unless both parties agree otherwise;

6.4.1.2 A list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose action gave rise to the hearing request;

6.4.1.3 The rights of the parties as set forth in Section 6.5.5:

6.4.1.4 Upon completion of the hearing, the Practitioner involved has the right:

6.4.1.4.1 To receive a record of the proceedings upon payment of a reasonable charge;

6.4.1.4.2 To receive the written recommendation of the hearing panel, including a statement of the basis for the recommendations;

6.4.1.4.3 To receive a written decision of the Board of Trustees, including a statement of the basis for the decision; and

6.4.1.5 The right to the hearing may be forfeited if the Practitioner fails, without good cause, to appear.

6.4.2 APPOINTMENT OF HEARING PANEL

6.4.2.1 By Medical Staff: A hearing occasioned by an adverse recommendation of the Medical Executive Committee shall be conducted by Hearing Panel appointed by the President of the Medical Staff.

6.4.2.2 By Board of Trustees: A hearing occasioned by an adverse action of the Board of Trustees shall be conducted by a hearing panel appointed by the Chairperson of Board of Trustees.

6.4.2.3 Composition of Hearing Panel: The hearing panel shall be composed of three (3) members. One of the members so appointed will be designated as the Chairperson of the Hearing Panel. The Chairperson of the Hearing Panel will preside over the hearing unless a separate Hearing Officer is appointed pursuant to Section 6.5.3. No Member may serve who has acted as accuser, investigator, fact finder, or initial decision maker in the matter. Knowledge of the matter shall not preclude a Member from serving. No Member shall be appointed who is in direct economic competition with the Practitioner, or is a Member of the Medical Executive Committee or Board of Trustees. At least one Member shall be of the same medical specialty as the Practitioner. A majority of the members shall be members of the Medical Staff. However, if there are not a sufficient number of Medical Staff members willing or able to serve on the hearing panel, the Medical Executive Committee or the Board of Trustees may appoint Practitioners who are not members of the Medical Staff.

6.4.2.4 Challenges for Cause: The Practitioner may question hearing panel members regarding potential bias, prejudice or conflict of interest and challenge any Member of the hearing committee for any cause, which would indicate bias or predisposition. The Chairperson of the Hearing Panel, or if challenged, the President of the Medical Staff, shall decide the validity of such challenges. His/her decision shall be final.

6.5 HEARING PROCEDURE

6.5.1 PERSONAL PRESENCE

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 6.3.4.

6.5.2 PRESIDING OFFICER

The Chairperson of the hearing panel shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

6.5.3 APPOINTMENT OF A HEARING OFFICER

The use of a hearing officer to preside at an evidentiary hearing or to conduct the hearing is optional. The use and appointment of such an officer shall be determined by the President of

the Medical Staff or by the Chairman of the Board of Trustees if the adverse action was taken by the Board of Trustees. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/she shall act as the presiding officer of the hearing. The hearing officer may be present during deliberations, but shall not vote. Once a hearing officer has been appointed, he or she may only be removed for cause by the President of the Medical Staff with CEO approval.

6.5.4 REPRESENTATION

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or another person of his/her choice. The Medical Executive Committee or the Board of Trustees, depending on whose recommendation or action promoted the hearing, shall appoint an individual to present the facts and argument in support of its adverse recommendation or action, and to examine witnesses.

6.5.5 RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right to:

6.5.5.1 Request a pre-hearing conference to resolve procedural issues (i.e., determine the documentation that the affected Practitioner has the right to receive, and the timeframe for exchanging documents and witness lists);

6.5.5.2 Request access to any documents or information determined to be relevant by the Hearing Panel Chairperson or Hearing Officer;

6.5.5.3 Be present at the hearing;

6.5.5.4 Representation by an attorney or other person;

6.5.5.5 Have a record made of the proceedings by use of a court reporter or an electronic recording unit, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;

6.5.5.6 Call, examine and cross-examine any witness on any matter relevant to the issues;

6.5.5.7 Present evidence and introduce exhibits determined to be relevant by the Chairperson of the Hearing Panel or the Hearing Officer regardless of its admissibility in a court of law;

6.5.5.8 Impeach any witness;

6.5.5.9 Rebut any evidence; and

6.5.5.10 Present an oral or written statement at the close of the hearing.

6.5.6 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. Hospital staff members and Medical Staff members cannot be compelled to testify against their will. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The concern of the hearing panel is with determining the truth of the matter, providing adequate safeguards for the rights of the parties and ultimate fairness to both parties. The hearing panel shall also be entitled to consider all other information including hearsay evidence that can be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges. At the hearing panel Chairperson's discretion, each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record.

The provision of documents and information to the Practitioner and in connection with the hearing shall not be deemed a waiver of the peer review privileges.

6.5.7 BURDEN OF PROOF

6.5.7.1 The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of their recommendation or action, but the Practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the recommendation or action lacks any substantial factual basis or that the adverse recommendation or action is either arbitrary, unreasonable, or capricious.

6.5.8 RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to permit a valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing panel may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. A court reporter shall be present if requested by any party (at the expense of the requesting party).

6.5.9 POSTPONEMENT

Request for postponement of a hearing shall be granted by the Chairperson of the Hearing Panel to a date agreeable to the hearing panel only by stipulation between the parties or upon a showing of good cause.

6.5.10 PRESENCE OF HEARING PANEL MEMBERS AND VOTE

All members of the hearing panel must be present throughout the hearing and deliberations.

6.5.11 RECESSES AND ADJOURNMENT

The hearing panel may recess the hearing and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing panel shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

6.6 HEARING PANEL REPORT AND FURTHER ACTION

6.6.1 HEARING PANEL REPORT

Within 14 days after the final adjournment of the hearing, the Hearing Panel shall make a written report of its findings and recommendations in the matter, as decided by a majority of the entire Hearing Panel, and shall forward the same, together with the hearing record and all other documentation considered by it, to the Chief Executive Officer for distribution to the Medical Executive Committee, or the Board of Trustees in the event the adverse action originated with the Board of Trustees, and the Practitioner.

6.6.2 ACTION ON HEARING PANEL REPORT

Within 30 days after receipt of the written report of the Hearing Panel, the Medical Executive Committee or Board of Trustees, as the case may be, shall consider the report and affirm, modify or reverse its recommendations in the matter. The Medical Executive Committee shall transmit, together with the hearing record, the report of the Hearing Panel and all other documentation considered, to the Chief Executive Officer.

6.6.3 NOTICE AND EFFECT OF RESULT

6.6.3.1 Notice: The Chief Executive Officer shall promptly send a copy of the Medical Executive Committee's recommendation and Hearing Panel's report to the Practitioner by written notice, and to the Board of Trustees.

6.6.3.2 Effect of Favorable Result:

6.6.3.2.1 Adopted by the Medical Executive Committee: If the Medical Executive Committee's recommendation is favorable to the Practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board of Trustees for its final action. The Board of Trustees shall take action thereupon by adopting, rejecting, or modifying the Medical Executive Committee's recommendation in whole or in part, or by referring the matter back to the Medical Executive Committee for further reconsideration. Any such referral back shall state the reasons for the referral, set a time limit within which a subsequent recommendation to the Board of Trustees must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board of Trustees shall within 30 days take final action. The Chief Executive Officer shall promptly send the Practitioner notice informing him/her of each action taken pursuant to this Section.

6.6.3.2.2 Adopted by the Board of Trustees: If the Board of Trustees' initial hearing action is favorable to the Practitioner, such result shall become the final decision of the Board of Trustees and the matter shall be considered closed.

6.6.3.3 Effect of Adverse Result for Practitioner: If the result of the Medical Executive Committee is adverse to the Practitioner or the action taken by the Board of Trustees continues to be adverse to the Practitioner in any of the respects listed in Section 6.3.1, the notice required by this Section shall inform the Practitioner of his/her right to request an appellate review by the Board of Trustees as provided in Section 6.7.1.

6.7 APPELLATE REVIEW

6.7.1 TIME FOR APPEAL

Within 10 days after receipt of notice pursuant to Section 6.6.3 of the Medical Executive Committee's recommendation or Board of Trustees' decision, either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within the 10 day period, an appeal is deemed to be waived

6.7.2 GROUNDS FOR APPEAL

The grounds for appeal shall be limited to the following:

6.7.2.1 There was substantial failure to comply with the Bylaws of the Hospital or Medical Staff during or prior to the hearing, so as to deny a fair hearing; and/or

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

6.7.3 TIME, PLACE AND NOTICE

Whenever an appeal is requested as set forth in the preceding Sections, the Chairperson of the Board of Trustees shall schedule and arrange for an appeal. The individual shall be given special

notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

6.7.4 NATURE OF APPELLATE REVIEW

6.7.4.1 The Board of Trustees may consider the appeal as a whole body, or the Chairperson of the Board of Trustees may appoint a Review Panel composed of three (3) persons, either members of the Board of Trustees or others, including, but not limited to, reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board of Trustees.

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

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

6.7.5 APPELLATE REVIEW IN THE EVENT OF BOARD OF TRUSTEES MODIFICATION OR REVERSAL OF HEARING PANEL RECOMMENDATION

If the Board of Trustees determines to modify or reverse the recommendation of a Hearing Panel in a matter in which the individual did not request appellate review, and such action would adversely affect the individual, the Board of Trustees shall notify the affected individual through the Chief Executive Officer that he or she may appeal the proposed modification or reversal. The Board of Trustees shall take no final action until the individual has exercised or has waived that appeal provided in these Bylaws. The Board of Trustees has the final say in the matter.

6.7.6 FINAL DECISION OF THE BOARD OF TRUSTEES

6.7.6.1 Within 30 days after the Board of Trustees (i) considers the appeal as an Appellate Review Panel, (ii) receives a recommendation from a separate Appellate Review Panel, or (iii) receives the Hearing Panel's and Medical Executive Committee's report and recommendation when no appeal has been requested, the Board of Trustees shall consider the matter and take final action.

6.7.6.2 The Board of Trustees may review any information that it deems relevant including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Appellate Review Panel. The Board of Trustees may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board of Trustees' ultimate legal authority for the operation of the Hospital and the quality of care provided.

6.7.6.3 The Board of Trustees shall render its final decision in writing, including specific reasons, and shall send special notice to the individual. A copy shall also be provided to the Medical Executive Committee for its information.

6.7.7 FURTHER REVIEW

Except where the matter is referred by the Board of Trustees for further action and recommendation by any individual or committee, the final decision of the Board of Trustees shall be effective immediately and shall not be subject to further review. If the matter is referred for

further action and recommendation, such recommendation shall be promptly made to the Board of Trustees in accordance with the instructions given by the Board of Trustees.

6.8 GENERAL PROVISIONS

6.8.1 BOARD OF TRUSTEES ACTION

The procedures specified herein shall not preclude the Board of Trustees from taking any direct action authorized under the Board of Trustees Bylaws, policies and/or procedures.

6.8.2 NUMBER OF HEARINGS AND REVIEW

Notwithstanding any other provision of the Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to a specific adverse recommendation or action.

6.8.3 RELEASE

By requesting a hearing or appellate review under this Article, a Practitioner agrees to be bound by the provisions in these Bylaws relating to immunity from liability in all matters relating thereto.

6.8.4 CONFIDENTIALITY

The investigations, proceedings and records conducted or created for the purpose of carrying out the provisions of the Fair Hearing Plan or for conducting peer review activities under the Medical Staff Bylaws are to be treated as confidential, protected by State and Federal Law.

6.8.5 HEARING AND APPEAL PROCEDURES FOR ADVANCED PRACTICE PROFESSIONALS

Individuals with clinical privileges who are not eligible for Medical Staff membership and who are not Medical Staff members (i.e., Advanced Practice Professionals - APPs) are afforded a fair hearing and appeal process but that process shall be a modified from that for Medical Staff members or applicants for Medical Staff membership. The following procedures shall be used for APPs:

6.8.5.1 Notice: Written notice of an adverse recommendation or action and the right to a hearing shall be promptly given to the APP subject to the adverse recommendation or action. The notice shall state that the APP has 30 days in which to request a hearing. If the APP does not request a hearing within 30 days, the APP shall have waived right to a hearing.

6.8.5.2 Hearing Panel: The Chief Executive Officer shall appoint a hearing panel, which will include three members. The panel members shall include the Chief Executive Officer, the President of the Medical Staff or another officer of the Medical Staff, and a peer of the APP who is not an economic competitor of the AAP in question. None of the panel members shall have had a role in the adverse recommendation or action.

6.8.5.3 Rights: The APP subject to the adverse recommendation or action shall have the right to present information, but cannot have legal representation or call witnesses.

6.8.5.4 Hearing Panel Determination: Following presentation of information and panel deliberations, the panel shall make a determination:

6.8.5.4.1 A determination favorable to the APP shall be reported in writing to the body making the adverse recommendation or action.

6.8.5.4.2 A determination adverse to the APP shall result in notice to the APP of the right to appeal the decision to the Chairperson of the Board of Trustees.

6.8.5.5 Final Decision: The decision of the Chairperson of the Board of Trustees shall be final.

6.8.6 EXTERNAL REPORTING REQUIREMENTS

The Hospital shall submit a report to the appropriate state professional licensure board (i.e., the state agency that issued the individual's license to practice) and all other agencies as required by all applicable Federal and/or State law(s) and in accordance with Hospital policy and procedures.

6.8.6.1 Such reporting is not an adverse recommendation or action entitling the individual to a right to a hearing under these Bylaws and is subject to the privileges and immunities as described in Article Eleven.

7 ARTICLE SEVEN: MEDICAL STAFF OFFICERS

7.1. ELECTED OFFICERS OF THE STAFF

7.1.1. IDENTIFICATION

The officers of the Medical Staff shall be the President, the President-Elect, the Secretary-Treasurer, and the Immediate Past President.

7.1.2. QUALIFICATIONS

Officers must be members of the active staff in good standing at the time of nomination and election and must continuously maintain such status during their terms of office. To qualify for the position of President or President-Elect, a Member of the Medical Staff must be a doctor of medicine (including a DDS/MD or osteopathy No Medical Staff Member actively practicing in the Hospital is ineligible for election to an officer position solely because of his/her professional discipline, specialty, or practice as a hospital-based physician. Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

7.1.2.1. Be appointed in good standing to the Active Staff, and have served on the Active Staff for at least five years;

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

7.1.2.3. Be willing to faithfully discharge the duties and responsibilities of the position;

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

7.1.2.5. Attend continuing education relating to medical staff leadership and/or credentialing functions during the term of the office.

7.2. TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTIONS

7.2.1. TERM OF OFFICE

Each officer shall serve a one (1) year term. The term of office shall commence on the first day of the medical staff year following the election. Each officer shall serve in office until the end his/her term or until a successor is duly elected and has qualified, unless he/she resigns, or is removed or recalled from office, or is otherwise unable to complete the term. At the end of the President's term, the President-Elect shall automatically assume that office, the Secretary-Treasurer shall automatically assume the office of President-Elect, and the President shall automatically serve as the Immediate Past President.

7.2.2. ELIGIBILITY FOR RE-ELECTION

No person may serve in the same position for more than two consecutive terms.

7.3. ATTAINMENT OF OFFICE

7.3.1. NOMINATION

At least ninety (90) days before the annual Staff meeting, the Nominating Committee shall convene and submit to the President one or more qualified nominees for any open office (including the Secretary-Treasurer if that individual does not wish to advance to President-Elect . The Nominating

Committee shall report the names of the nominees to the Staff at least sixty (60) days before the annual meeting. Nominations may also be made by petition signed by at least ten percent of the appointees of the active staff, with a signed statement of willingness to serve by the nominee, filed with the President at least forty-five (45) days before the annual meeting. As soon thereafter as reasonably possible, the names of the additional nominees will be reported to the Staff. If, before the election, all nominees refuse or are disqualified or are otherwise unable to accept nomination, the Nominating Committee shall submit one or more additional nominees at the annual meeting and nominations may be accepted from the floor if the nominee is present at the meeting and consents to the nomination.

7.3.2. ELECTION

The Nominating Committee shall list the nominees on a written ballot and distribute the ballot to staff members eligible to vote. In no event shall the written ballot be sent less than thirty (30) days prior to the annual general Medical Staff meeting. The written ballot shall make provision for eligible Medical Staff members to vote for write-in candidates. Nominations may also be made from the floor at the time of the annual general Medical Staff meeting. Members of the Nominating Committee shall not be eligible for the nominee list.

To be counted in the vote, the written ballot must be returned to the Medical Staff Office at least ten (10) days before the annual general Medical Staff meeting. The nominee receiving the majority of votes shall be elected. If there is no majority vote for any one candidate as determined prior to the meeting, notice will be mailed to the eligible voters, within seven (7) days of the annual meeting, informing them that successive balloting of those present will be held at the annual meeting. The elected officer shall be announced at the annual meeting of the Medical Staff. Voting by proxy shall not be permitted.

7.3.3. BOARD RATIFICATION/INDEMNIFICATION

To afford the Medical Staff officers and others the full protections of the Healthcare Quality Improvement Act, the Board shall ratify the appointments of Medical Staff officers and other leaders, such as Department officers, who will perform professional review regarding competence or professional conduct of Practitioners and other individuals requesting clinical privileges, such as credentialing or quality assessment/performance improvement activities. The Board's ratification shall serve as evidence that they are charged with performing important Hospital functions when engaging in credentialing or quality assessment/performance improvement activities. Such activities shall have the following characteristics:

7.3.3.1. The activities such leaders undertake shall be performed on behalf of the Hospital;

7.3.3.2. The activities shall be performed in good faith,

7.3.3.3. That any professional review action shall be taken:

7.3.3.3.1. In the reasonable belief that the action was in the furtherance of quality health care;

7.3.3.3.2. After a reasonable effort to obtain the facts of the matter;

7.3.3.3.3. After adequate notice and hearing procedures are afforded to the individual involved or after such other procedures as are fair to the individual under the circumstances; and,

7.3.3.3.4. In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting this Section.

7.3.3.4. The activities shall follow procedures set forth in these Bylaws, rules and regulations, or policies;

7.3.3.5. Medical Staff leaders who are performing activities meeting the above listed criteria shall qualify for indemnification for those activities through the Hospital.

7.4. VACANCIES

7.4.1. WHEN CREATED

Vacancies in office may occur from time to time, such as upon the death, disability, resignation, removal, or recall from office of an officer, or upon an officer's failure to maintain active staff status in good standing.

7.4.2. OFFICE OF THE PRESIDENT

When a vacancy occurs in the office of the President, then the President-Elect shall serve the remaining term of the former President. The vacancy then created in the office of President-Elect shall be filled as described in these Bylaws. In the event of the simultaneous vacancy in both the President and President-Elect positions or in all of the officer positions, the Board shall appoint interim officers to fill these positions and an election shall be conducted within ninety (90) days. An ad hoc nominating committee appointed by the Board shall convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following nomination of candidates, the Medical Staff shall hold a special meeting, or send out a ballot, to conduct elections for these offices, using the election procedures described in these Bylaws.

7.4.3. MEDICAL STAFF OFFICERS (OTHER THAN THE PRESIDENT)

When a vacancy occurs in the office of the President-Elect, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election, when both a President and President-Elect shall be elected. When a vacancy occurs in the office of the Secretary-Treasurer, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election. When a vacancy occurs in the office of the Immediate Past President, the office shall remain vacant until after the next election.

7.5. RESIGNATION, REMOVAL, AND RECALL FROM OFFICE

7.5.1. RESIGNATION

Any medical staff officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

7.5.2. REMOVAL

Any elected Medical Staff officer or a member of the Medical Executive Committee may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether there is sufficient evidence for grounds for removal from office for cause, with approval by the Board, or with the majority vote of the Board. Grounds for removal may include any one or more of the following causes, without limitations:

7.5.2.1. Failure to perform the duties of office;

7.5.2.2. Failure to comply with or support the enforcement of the hospital and Medical Staff Bylaws, Rules and Regulations, or policies;

7.5.2.3. Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;

7.5.2.4. Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing; and/or,

7.5.2.5. Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.

At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action shall be taken. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Board of Trustees prior to a vote on removal.

7.5.3 RECALL FROM OFFICE

Any elected Medical Staff officer or a member of the Medical Executive Committee may be recalled from office, with or without cause. Recall of a Medical Staff officer or a member of the Medical Executive Committee may be initiated by a majority of members of the Medical Executive Committee or by a petition signed by at least one-third of the medical staff members eligible to vote in Medical Staff elections. Recall shall be considered by the Medical Staff at a special meeting of the Medical Staff called for that purpose. A recall shall require two-thirds of the votes of the Medical Staff members attending the specially called meeting who are eligible to vote. Sealed and authenticated votes mailed by Medical Staff members eligible to vote shall also be counted at the special meeting. The recall shall become effective upon approval of the Board.

7.6. RESPONSIBILITIES AND AUTHORITY OF THE ELECTED OFFICERS

7.6.1. PRESIDENT

The President shall serve as the chief administrative officer of the Medical Staff and shall have responsibility for the organization and conduct of the Medical Staff, and supervision of the general affairs of the Medical Staff. The specific responsibilities, duties, and authority of the President are to:

7.6.1.1. Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff;

7.6.1.2. Serve as chairperson of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

7.6.1.3. Serve as ex-officio Member of all other Medical Staff committees without vote, unless otherwise specified;

7.6.1.4. Appoint and discharge the Chairpersons of all Medical Staff standing and ad hoc committees, recommend to the Medical Executive Committee the members of all Medical Staff standing and ad hoc committees, and appoint Medical Staff members of Hospital and Board committees, except when these memberships are designated by position or by specific direction of the Board;

7.6.1.5. Be responsible for the enforcement of these Bylaws, the Rules and Regulations, and Medical Staff and Hospital policies, implement sanctions when indicated, and enforce the Medical Staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner or other individual with clinical privileges;

7.6.1.6. Be accountable and responsible to the Board for the quality and efficiency of clinical services and professional performance of the Medical Staff in the provision of patient care services;

7.6.1.7. Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the President and CEO and the Board, and serve as an ex-officio Member of the Board, with a vote;

7.6.1.8. Receive and interpret the opinions, policies, and directives of the Administration and the Board to the Medical Staff;

7.6.1.9. Act as the representative of the Medical Staff to the public as well as to other health care providers, other organizations, and regulatory or accrediting agencies in external professional and public relations; and,

7.6.1.10. Perform all other functions as may be assigned to the President by these Bylaws, the Medical Staff, the Medical Executive Committee, or by the Board.

7.6.2. PRESIDENT-ELECT

The President-Elect shall perform the duties of the President in the absence or temporary inability of the President to perform. The President-Elect shall serve as the vice-chairperson of the Medical Executive Committee, chairperson of the Credentials Committee, and shall perform such additional duties as may be assigned by the President or the Board.

7.6.3. SECRETARY-TREASURER

The Secretary-Treasurer shall be a Member of the Medical Executive Committee. The duties of the Secretary-Treasurer are to:

7.6.3.1. Maintain a roster of Medical Staff members;

7.6.3.2. Keep accurate and complete minutes of all Medical Executive Committee and general Medical Staff meetings;

7.6.3.3. Assure that all notices of Medical Staff meetings are given as provided in these Bylaws, on order of the President;

7.6.3.4. Be custodian of Staff records and attend to all appropriate correspondence and notices on behalf of the Medical Staff; and,

7.6.3.5. Maintain a record of Medical Staff dues, collections, and accounts, and sign checks for the Medical Staff fund expenditures pursuant to his/her authority.

7.6.4. IMMEDIATE PAST PRESIDENT

As an individual with unique knowledge of Medical Staff affairs, the Immediate Past President shall serve as an advisor and mentor to the President, shall participate as a Member of the Medical Executive Committee and other standing committees of the Medical Staff as specified in these Bylaws, and shall perform other duties as requested by the President.

8 ARTICLE EIGHT: CLINICAL DEPARTMENTS/DISCIPLINES

8.1 DESIGNATION:

Each clinical Department shall be organized as a separate component of the organized Medical Staff and shall have a Chairperson who shall be responsible for the overall supervision of the clinical work within the Department.

8.1.1 CURRENT CLINICAL DEPARTMENTS/DISCIPLINES

The following Departments are established. Additional Departments, as required from time to time, may be established by the Board of Trustees after considering recommendations from the Medical Executive Committee.

8.1.1.1 Department of Anesthesiology

8.1.1.1.1 Discipline of Anesthesiology

8.1.1.1.2 Discipline of Pain Management

8.1.1.2 Department of Emergency Medicine

8.1.1.3 Department of Family Medicine

8.1.1.4 Department of Medicine

8.1.1.4.1 Discipline of Allergy/Immunology

8.1.1.4.2 Discipline of Cardiology

8.1.1.4.3 Discipline of Dermatology

8.1.1.4.4 Discipline of Endocrinology

8.1.1.4.5 Discipline of Gastroenterology

8.1.1.4.6 Discipline of Hematology/Oncology

8.1.1.4.7 Discipline of Infectious Disease

8.1.1.4.8 Discipline of Internal Medicine

8.1.1.4.9 Discipline of Nephrology

8.1.1.4.10 Discipline of Neurology

8.1.1.4.11 Discipline of Physical Medicine and Rehabilitation

8.1.1.4.12 Discipline of Psychiatry

8.1.1.4.13 Discipline of Pulmonology

8.1.1.4.14 Discipline of Rheumatology

8.1.1.4.15 Discipline of Wound Care

8.1.1.5 Department of Obstetrics and Gynecology

8.1.1.6 Department of Pathology

8.1.1.7 Department of Pediatrics

8.1.1.8 Department of Radiology/Radiation Oncology

8.1.1.9 Department of Surgery

8.1.1.9.1 Discipline of Cardiovascular Surgery

8.1.1.9.2 Discipline of Colorectal Surgery

8.1.1.9.3 Discipline of Dentistry/Oral Surgery

8.1.1.9.4 Discipline of General Surgery

8.1.1.9.5 Discipline of Ophthalmology

8.1.1.9.6 Discipline of Otorhinolaryngology

8.1.1.9.7 Discipline of Neurosurgery

8.1.1.9.8 Discipline of Orthopedic Surgery

8.1.1.9.9 Discipline of Plastic Surgery

8.1.1.9.10 Discipline of Podiatry

8.1.1.9.11 Discipline of Thoracic Surgery

8.1.1.9.12 Discipline of Urology

8.1.1.9.13 Discipline of Vascular Surgery

8.2 CRITERIA TO QUALIFY AS A DEPARTMENT

The Medical Executive Committee may create, eliminate, subdivide or combine Departments subject to approval by the Board, based on the evolving scope of clinical services of the Hospital and the need of the Medical Staff organization to most effectively support the oversight of quality of patient care. Since the primary function of a Departments to be responsible for the quality of patient care provided by the members of the Department, the primary criteria for creating or subdividing a Department, or in eliminating or combining a Department shall be whether the Department has a sufficient number of active staff members and sufficient patient volume to support the quality assessment and performance improvement activities required of a Department. To qualify as a Department, there shall be active staff members in a clinically distinct area of medical practice with sufficient patient volume to support meaningful ongoing quality assessment and performance improvement activities.

8.3 REQUIREMENTS FOR AFFILIATION WITH DEPARTMENTS

Each Medical Staff Member and other individuals with clinical privileges shall be assigned to one Department by the Board based on recommendations from the Medical Executive Committee. A Medical Staff Member or other individual with clinical privileges may be assigned to a Division if one exists related to the Member's or individual's clinical specialty. A Member or other individual with clinical privileges may be granted clinical privileges in one or more other Departments. The exercise of clinical privileges within any Department shall be subject to the rules and regulations of the Department and the authority of the Department Chairperson.

8.4 FUNCTIONS OF DEPARTMENTS

The Departments shall meet at least biannually to perform the following functions:

8.4.1 CLINICAL FUNCTIONS

8.4.1.1 Serve as a forum for the exchange of clinical information regarding services provided by Department members;

8.4.1.2 Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to the development of clinical practice guidelines related to care and services provided by Department members;

8.4.1.3 Provide recommendations to the Department Chairperson regarding professional criteria for clinical privileges designed to assure the Medical Staff and Board that patients shall receive quality care. The recommendations shall include:

8.4.1.3.1 Criteria for granting, withdrawing and modifying clinical privileges;

8.4.1.3.2 A procedure for applying these criteria to individuals requesting privileges.

8.4.1.4 Ensure that patients receive appropriate and medically necessary care from a Member of the Medical Staff during the entire length of stay with the Hospital;

8.4.1.5 Ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within the Department, across Departments, and between members and non-members of the Medical Staff with clinical privileges;

8.4.1.5.1 By establishing uniform patient care processes;

8.4.1.5.2 By establishing similar clinical privileging criteria for similar privileges;

8.4.1.5.3 By using similar indicators in performance improvement activities.

8.4.1.6 Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to issues related to standards of practice and/or clinical competence;

8.4.1.7 Ensure effective mechanisms for the clinical supervision of Advanced Practice Professionals, and House Staff practitioners, if any.

8.4.2 ADMINISTRATIVE FUNCTIONS

8.4.2.1 Provide information and/or recommendations to the Department Chairperson with regard to the criteria for granting clinical privileges within the Department;

8.4.2.2 Ensure that individuals within the Department who admit patients have privileges to do so, and that all individuals within the Department with clinical privileges only provide services within the scope of privileges granted.

8.4.2.3 Provide information and/or recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to Medical Staff Policies;

8.4.2.4 Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to ensuring appropriate call coverage by Department members.

8.4.3 QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY ACTIVITIES

8.4.3.1 Perform peer review and quality assessment activities relative to the performance of individuals with clinical privileges in the Department and report such activities to the Medical Executive Committee on a regular basis;

8.4.3.2 Provide leadership for activities related to patient safety, including proactive risk assessments, root cause analysis in response to an unanticipated adverse event, addressing patient safety alerts, and implementing procedures to comply with patient safety goals.

8.4.3.3 Ensure appropriate quality control is performed, if applicable to the Department;

8.4.3.4 Receive reports regarding Hospital performance improvement results that are applicable to the performance of the Department and its members, and integrate the Department's performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital Performance Improvement Plan.

8.4.4 COLLEGIAL AND EDUCATIONAL FUNCTIONS

8.4.4.1 Recommend medical educational programs to meet the needs of Department members, based on the scope of services provided by the Department, changes in medical practice or technology, and the results of Departmental performance improvement activities.

8.5 DEPARTMENT OFFICERS

8.5.1 IDENTIFICATION

The officers of the Departments shall be the Department Chairperson and the Department Vice-Chairperson.

8.5.2 QUALIFICATIONS

The officers of the Departments shall be active staff members in good standing. Each Department Chairperson and Vice-Chairperson shall have demonstrated ability in at least one of the clinical areas of the Department. All officers of the Departments shall be certified by an appropriate specialty board, or affirmatively establishes comparable competence through the credentialing process.

8.5.2.1 Each Department Chairperson shall:

8.5.2.1.1 Be an Active Staff member;

8.5.2.1.2 Be certified by an appropriate specialty board or equivalent, as determined through the credentialing and privileging process; and

8.5.2.1.3 Satisfy the eligibility criteria set forth for Medical Staff Officers.

8.5.3 ATTAINMENT OF OFFICE

Department officers shall be elected by a majority vote of the Department members eligible to vote, or as defined by Department contract, subject to the approval of the Executive Committee and Governing Body in the following manner: The election in each department shall follow presentation of a slate of department officers, one month prior to the election, by a nominating committee consisting of at least three (3) Members of the department appointed by the Chairperson of the department. At the time of the election, nominations from the floor will be in order. However, no officers shall take office without approval by the Governing Body. The appointment shall be for a period of one year consistent with the Medical Staff year. If the Governing Body does not approve the results of the election, new election(s) shall be held until a candidate acceptable to the Governing Body has been elected. Until such time, the existing Chairperson or Vice Chairperson, or if this position is vacated, an interim Chairman or Vice Chairperson appointed by the President of the Medical Staff and approved by the Executive Committee and Governing Body, will act as Chairperson. Department officers may succeed themselves. The officers selected during the election shall be subject to ratification by the Board and shall take office at the beginning of the subsequent medical staff year. Terms of office of Clinical Department chairpersons will be at the discretion of the individual departments.

8.5.4 RESIGNATION

Any Department officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

8.5.5 REMOVAL

Any Department officer may be removed from office for cause. Removal of a Department Chairperson or Vice-Chairperson from office may be initiated by written request from twenty percent (20%) of the Members of the Chairperson's or Vice-Chairperson's Department who

are eligible to vote. Such removal may be effected by a majority vote of the Department's Members eligible to vote. The Secretary-Treasurer of the Medical Staff shall count ballots with the cooperation of the Medical Staff Office and report the results to the Executive Committee. Removal shall occur with the majority vote of the Medical Executive Committee as to whether sufficient evidence exists for grounds for removal, with approval by the Board, or with the majority vote of the Board. Grounds for removal may include any one or more of the following causes, without limitations:

8.5.5.1 Failure to perform the duties of office;

8.5.5.2 Failure to comply with or support the enforcement of the Hospital and Medical Staff Bylaws, Rules and Regulations, or policies;

8.5.5.3 Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;

8.5.5.4 Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing and/or failure to maintain specialty board certification or comparable competence; and/or,

8.5.5.5 Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.

At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action shall be taken. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Board of Trustees prior to a vote on removal. Removal from office is not an adverse action and does not trigger the fair hearing and appeal opportunities described in Article Seven of these Bylaws.

8.5.6 RECALL

Any Department officer may be recalled from office, with or without cause. Recall of a Department officer may be initiated by a petition signed by at least one-third of the Department members eligible to vote in medical Staff-Elections. Recall shall be considered by the members of the Department at a special meeting of the Department called for that purpose. A recall shall require two-thirds of the votes of the Department members attending the specially called meeting who are eligible to vote. Sealed, authenticated votes mailed by Department members eligible to vote shall also be counted at the special meeting. The recall shall become effective upon approval of the Board.

8.5.7 VACANCY

In the event of a vacancy in one of the Department officer positions, the President shall appoint an interim officer until an election can be held at the next Department meeting.

8.5.8 RESPONSIBILITY AND AUTHORITY

8.5.8.1 Department Chairperson: Each Department Chairperson shall be responsible for the organization of the Department and delegation of duties to Department members to promote quality of patient care in the Department. Members of the Department and others with clinical privileges in the Department shall be responsible to the Department Chairperson. Each Department Chairperson shall be responsible for the following duties:

8.5.8.1.1 Presiding at all meetings of the Department;

8.5.8.1.2 Assuming the necessary responsibility to assure the continuous care of patients admitted to the hospital under the care of a practitioner in his Department;

8.5.8.1.3 Serving as an ex-officio Member of all departmental committees if any, without vote, unless specifically stated in the Bylaws or Rules and Regulations otherwise;

8.5.8.1.4 Serving as a Member of the Medical Executive Committee and be accountable to the Medical Executive Committee with regard to the activities and functioning of the Department, specifically to regularly report the quality assessment and performance improvement activities of the Department to the Medical Executive Committee;

8.5.8.1.5 Conducting all clinically related activities of the Department;

8.5.8.1.6 Conducting all administratively related activities of the Department, unless otherwise provided by the Hospital;

8.5.8.1.7 Continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges;

8.5.8.1.8 Participating in the evaluation of Practitioners practicing within the department;

8.5.8.1.9 Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department;

8.5.8.1.10 Recommending clinical privileges for each Member of the Department;

8.5.8.1.11 Assessing and/or recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or the Hospital;

8.5.8.1.12 Integrating the Department into the primary functions of the Hospital;

8.5.8.1.13 Coordinating and integrating interdepartmental and intradepartmental services;

8.5.8.1.14 Developing and implementing policies and procedures that guide and support the provision of services;

8.5.8.1.15 Recommending a sufficient number of qualified and competent persons to provide care or services, including ER call coverage;

8.5.8.1.16 Determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services;

8.5.8.1.17 Ensuring the continuous assessment and improvement of the quality of care and services provided;

8.5.8.1.18 Maintaining quality control programs, as appropriate;

8.5.8.1.19 Ensuring the orientation and continuing education of all persons in the Department;

8.5.8.1.20 Recommending appropriate space and other resources needed by the Department.

8.5.8.2 Department Vice-Chairperson: The Vice-Chairperson shall assist the Department Chairperson in the performance of the Chairperson's duties, and shall assume the duties of the Chairperson in his/her absence. The Vice-Chairperson shall serve on the Medical Staff Peer Review Committee.

9 ARTICLE NINE: FUNCTIONS AND COMMITTEES

9.1 FUNCTIONS OF THE STAFF

Individual members of the Medical Staff and others with clinical privileges care for patients within an organization context. Within this context, members of the Medical Staff and those individuals with clinical privileges, as individuals and as a group, interface with, and actively participate in important organization functions. Key functions of the Medical Staff are outlined below, and are performed through the Departments, Divisions, and committees that compose the Medical Staff structure.

9.1.1 GOVERNANCE

Although the Medical Staff is an integral part of the Hospital and is not a separate legal entity, the Medical Staff is organized to perform its required functions. The Medical Staff organization shall:

9.1.1.1 Establish a framework for self-governance of Medical Staff activities and accountability to the Board.

9.1.1.2 Establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the Hospital.

9.1.2 PLANNING

The leaders of the Hospital include members of the Board, the President and CEO and other senior managers, Department leaders, the elected and the appointed leaders of the Medical Staff and the Medical Staff Departments and other Medical Staff members in medico-administrative positions, and the Chief Nursing Officer and other senior nursing leaders. Medical Staff leaders, as defined above, shall participate individually and collectively in collaborating with other Hospital leaders in the performance of the following leadership planning activities:

9.1.2.1 Planning patient care services;

9.1.2.2 Planning and prioritizing performance improvement activities;

9.1.2.3 Budgeting;

9.1.2.4 Providing for uniform performance of patient care processes, including providing a mechanism to ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;

9.1.2.5 Recruitment, retention, development, and continuing education of all staff;

9.1.2.6 Consideration and implementation of clinical practice guidelines as appropriate to the patient population.

9.1.2.7 Establishing and maintaining responsibility for written policy and procedures governing medical care provided in the emergency service or department.

9.1.2.8 When emergency services are provided at the Hospital but not at one or more off-campus locations of the Hospital, the Medical Staff shall have policy and procedures for appraisal of emergencies, initial treatment, and referral of patients at the off-campus locations.

9.1.2.9 The Medical Staff shall attempt to secure autopsies in all cases of unusual deaths and of medical legal and educational interest.

9.1.2.10 The Medical Staff, specifically the attending physician, shall be informed of autopsies that the Hospital intends to perform.

9.1.3 CREDENTIALING

The Medical Staff is fully responsible to the Board for the credentialing process, which includes a series of activities designed to collect relevant data that will serve as a basis for decisions regarding appointments and reappointments to the Medical Staff, as well as delineation of clinical privileges. The Medical Staff shall perform the following functions to ensure an effective credentialing process:

9.1.3.1 Establish specifically defined mechanisms for the process of appointment and reappointment to Medical Staff membership, and for granting delineated clinical privileges to qualified applicants.

9.1.3.2 Establish professional criteria for membership and for clinical privileges.

9.1.3.3 Conduct an evaluation of the qualifications and competence of individuals applying for Medical Staff membership or clinical privileges.

9.1.3.4 Submit recommendations to the Board regarding the qualifications of an applicant for appointment, reappointment or clinical privileges.

9.1.3.5 Establish a mechanism for fair hearing and appellate review.

9.1.3.6 Establish a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted.

9.1.4 QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

The Board requires that the Medical Staff is accountable to the Board for the quality of care provided to patients. All Medical Staff members and all others with delineated clinical privileges shall be subject to periodic review and appraisal as part of the Hospital's quality assessment and performance improvement activities. All organized services related to patient care shall be evaluated. The Hospital's quality assessment and performance improvement activities shall be described in detail in the Performance Improvement Plan. Through the activities of the Medical Staff Departments, the Medical Staff Quality/Peer Review Committee, and representation of the Medical Staff on Hospital performance improvement committees and teams, the Medical Staff shall perform the roles in quality assessment and performance improvement that are listed below. The Medical Staff shall ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff members and the Board of Trustees.

9.1.4.1 Medical Staff Executive Role in Performance Improvement. The Medical Staff shall participate with the Board and Administration in the performance of executive responsibilities related to the Hospital quality assessment and performance improvement program. The Board, the Medical Staff, and Administration shall be responsible and accountable for ensuring the following:

9.1.4.1.1 That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.

9.1.4.1.2 That the Hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated.

9.1.4.1.3 That clear expectations for safety are established.

9.1.4.1.4 That adequate resources are allocated for measuring, assessing, improving, and sustaining the Hospital's performance and reducing risk to patients.

9.1.4.1.5 That the determination of the number of distinct improvement projects is conducted annually.

9.1.4.2 Medical Staff Leadership Role in Performance Improvement: The Medical Staff shall perform a leadership role in the Hospital's quality assessment, performance improvement, and patient safety activities when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges. Such activities may include, but are not limited to a review of the following:

9.1.4.2.1 Use of patient safety data, proactive risk assessment and risk reduction activities, and implementation of procedures to respond to patient safety alerts and comply with patient safety goals;

9.1.4.2.2 Root cause analysis, investigation and response to any unanticipated adverse events;

9.1.4.2.3 Medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;

9.1.4.2.4 Review and analysis of performance based on the results of core measures and other publicly reported performance information;

9.1.4.2.5 Use of information about adverse privileging decisions for any Practitioner privileged through the medical staff process;

9.1.4.2.6 Use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;

9.1.4.2.7 Use of blood and blood components, including the review of any significant transfusions reactions;

9.1.4.2.8 Use of operative and other procedures, including tissue review and the review of any major discrepancy between pre-operative and post-operative (including pathological) diagnoses;

9.1.4.2.9 Review of appropriateness, medical necessity, and efficiency of clinical practice patterns, including the review of surgical appropriateness, readmissions, appropriateness of discharge, and resource/utilization review;

9.1.4.2.10 Significant departures from established patterns of clinical practice, including review of any sentinel events, risk management reports and patient or staff complaints involving the Medical Staff; and,

9.1.4.2.11 Use of developed criteria for autopsies.

9.1.4.3 Medical Staff Participant Role in Performance Improvement: The Medical Staff shall participate in the measurement, assessment, and improvement of other patient care processes. Such activities may include, but are not limited to a review of the following:

9.1.4.3.1 Analyzing and improving patient satisfaction;

9.1.4.3.2 Education of patients and families;

9.1.4.3.3 Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and,

9.1.4.3.4 Accurate, timely, and legible completion of patients' medical records, including a review of medical record delinquency rates;

9.1.4.3.5 The quality of history and physical exams;

9.1.4.3.6 Surveillance of nosocomial infections.

9.1.4.4 Medical Staff Peer Review: Findings relevant to an individual are used in an ongoing evaluation of the individual's competence. When the findings of quality assessment or performance improvement activities are relevant to an individual's performance and the individual is a Medical Staff Member or holds clinical privileges, the Medical Staff is responsible for determining the use of the findings in peer review or the ongoing evaluations of the individual's competence. In accordance with these Bylaws, clinical privileges are renewed or revised appropriately.

9.1.5 CONTINUING AND GRADUATE MEDICAL EDUCATION

Since the Medical Staff recognizes continuing education as an adjunct to maintaining clinical skills and current competence, all individuals with clinical privileges shall participate in continuing education. In supporting high quality patient care, the Hospital and the Medical Staff shall sponsor educational activities that are consonant with the Hospital's mission, the patient population served, and the patient care services provided, within the limitations of applicable Federal laws and Hospital policy. The Medical Staff shall develop educational programs for Medical Staff members and others with clinical privileges related at least in part to:

9.1.5.1 The type and nature of care offered by the hospital; and,

9.1.5.2 The findings of performance improvement activities.

Additionally, the Medical Staff shall support affiliated professional graduate medical education programs by developing and upholding rules and regulations and policies to provide for supervision by members of the Medical Staff of residents in carrying out their patient care responsibilities.

9.1.6 BYLAWS REVIEW AND REVISION

The Medical Staff shall provide a mechanism for adopting and amending the Medical Staff Bylaws, Rules and Regulations, and policies and for reviewing and revising the Medical Staff Bylaws, Rules and Regulations, and policies as necessary to:

9.1.6.1 Remain consistent with the Bylaws of the Board of Trustees;

9.1.6.2 Remain in compliance with all applicable Federal and State laws and regulations, and applicable accreditation standards;

9.1.6.3 Remain current with the Medical Staff's organization, structure, functions, responsibilities and accountabilities; and,

9.1.6.4 Remain consistent with Hospital policies.

9.1.7 MEDICAL STAFF LEADERSHIP DEVELOPMENT & NOMINATING

The Medical Staff shall provide a mechanism for developing future medical staff leaders by defining desired leadership characteristics, identifying and recruiting future potential medical staff leaders from among the Members of the Medical Staff, and determining the education and development needs of potential medical staff leaders so as to be successful in future roles. The Medical Staff shall provide a mechanism for selecting qualified officers to give leadership to the Medical Staff organization.

9.2 PRINCIPLES GOVERNING COMMITTEES

The key functions of the Medical Staff shall be performed ongoing through the activities of the Departments and committees of the Medical Staff. Specific key functions of the Medical Staff shall be performed through Medical Staff standing committees. The Medical Executive Committee may recommend to the Board the addition, deletion or modification of any standing committee of the Medical Staff with the exception of the Medical Executive Committee. Such recommendations will be enacted following approval by the Board. In addition to the standing committees, the Medical Executive Committee or the President may designate a subcommittee of any standing committee or a special committee. The composition, duties and authority, and procedures for meetings and reporting of any subcommittee or special committee shall be specified in written policies or plans that are approved by the Medical Executive Committee. The continued need for a subcommittee or special committee shall be evaluated when the policy or plan that specifies the function of the committee is due for appraisal, which shall be at least every three years. If continued need for the subcommittee or special committee is no longer present, the subcommittee or special committee may be abolished upon approval of the Medical Executive Committee.

9.3 DESIGNATION

The current standing committees of the Medical Staff are the Medical Executive Committee, the Credentials Committee, the Practitioner Health Committee, the Quality/Peer Review Committee, the Library and Medical Education Committee, the Bylaws Committee, the Medical Records Committee, and the Medical Staff Nominating Committee.

9.4 OPERATIONAL MATTERS RELATING TO COMMITTEES

9.4.1 REPRESENTATION ON HOSPITAL COMMITTEES

In addition to the provisions of this Article, the leaders of the Medical Staff may collaborate with other Hospital leaders in planning for the performance of certain interdisciplinary functions through the establishment of Hospital committees. When a Hospital committee shall be involved in deliberations affecting the discharge of Medical Staff responsibilities, the Hospital committee shall include Medical Staff representation and participation. Medical Staff representatives for a Hospital committee shall be appointed by the President with input from the President and CEO.

9.4.2 EX OFFICIO MEMBERS

The President and CEO shall be an ex-officio member of all Medical Staff committees. The President and CEO may designate another senior administrative Member to attend any meeting in his/her place. At the prerogative of the Board of Trustees, Board Member(s) may be appointed by the Board of Trustees to serve as representative(s) of the Board of Trustees on any Medical Staff committee or Hospital committee. Other ex-officio members of specific standing committees shall be defined in the committee composition for each committee.

9.4.3 APPOINTMENT OF CHAIRPERSON AND MEMBERS

Prior to the end of each Medical Staff year, the President shall appoint Medical Staff members to Medical Staff standing committee positions due to be vacated at the start of the next Medical Staff year. Terms of appointment shall commence at the start of the next Medical Staff year. Appointment of the chairpersons and any appointed members of the Medical Executive Committee, Credentials Committee, Quality/Peer Review Committee and any other committee performing a professional review activity shall be subject to ratification by the Board per Article Seven, Section 7.3.3 of these Bylaws. The President/CEO, in consultation and with the approval of the President, shall make administrative staff appointments to a Medical Staff committee. Unless otherwise

specified, administrative staff members serving on a Medical Staff committee shall not have the right to vote.

9.4.4 TERM, PRIOR REMOVAL AND VACANCIES

Unless specified otherwise, a committee chairperson or committee Member shall be appointed for a term of one (1) year, and shall serve until the end of the Medical Staff year and until his successor shall take office. If a chairperson or Member of a committee fails to maintain Medical Staff membership in good standing or fails to attend, participate or perform the duties of the committee position, the President, President, the Medical Executive Committee, or the Board may remove that Member from the committee position by a majority vote. As a condition of serving on a committee, and by virtue of having accepted the appointment, each Member agrees to participate on the committee and further agrees not to divulge any of the peer review or other confidential proceedings of the committee. Failure to abide by the confidentiality requirements for such proceedings shall subject the Member to removal from the committee and possible corrective actions, as warranted. Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

9.4.5 NOTICE

Notice of a committee meeting may be given in the same manner as notice for Medical Staff meetings, but in addition, notice for a committee meeting may be given orally and may be given not less than three (3) days before the meeting.

9.4.6 MEETINGS

The frequency of meeting shall be defined in writing for each committee, and shall be appropriate to the duties and functions of the committee. All business meetings for all committees, subcommittees, and Departments shall be held on the campus of the Hospital whenever possible. Meetings may also be held through secure teleconference or secure web-based technology provided that off-site participants are able to view all of the documentation being presented, are able to interactively participate in the discussion, and are able to cast their vote either verbally, or through an approved alternative, i.e., web-supported voting system, fax, or email as approved by the Hospital.

9.4.7 QUORUM

The active Medical Staff members present at a committee meeting shall constitute a quorum at any meeting provided, however, that at least two (2) persons are present at any such meeting.

The Executive Committee, Credentials Committee, and Peer Review Committee shall have no fewer than fifty percent (50%) of its voting members present in order to conduct business.

9.4.8 MANNER OF ACTING

Once a quorum has been established, a committee shall take action with a majority of the votes by those who are present and who have voting rights. No action of a committee shall be valid unless taken at a meeting at which a quorum is present; however, any action which may be taken at a meeting may be taken without a meeting if consent in writing, setting forth the action, is signed by a majority of the members of the committee entitled to vote. Once a quorum has been established, all business on the agenda may be conducted, even if the quorum is lost, unless the number of yes votes and the number of no votes differ by only one (1) vote.

9.4.9 ACTION THROUGH SUBCOMMITTEES

Unless specifically delegated in a subcommittee's written scope of authority, a subcommittee shall not take any action that requires the vote of the committee to which it reports. The subcommittee shall submit recommendations, to be acted on by the committee.

9.4.10 MINUTES

Each committee and subcommittee shall record minutes of each meeting in a format specified in Hospital policy and recorded in English. The minutes shall record the date and time of the meeting, the names of those attending the meeting, the items of business brought before the committee or subcommittee, and the committee's or subcommittee's conclusions, recommendations, actions and plans for follow-up. A copy of all meeting minutes, and all reports, records or other materials of each committee shall be kept and maintained in the Hospital for at least the current year plus three (3) years, after which they may be placed in archive storage, for perpetuity.

9.4.11 PROCEDURE

Each committee may formally or informally adopt its own rules of procedure, which shall not be inconsistent with the terms of its creation or these Bylaws.

9.4.12 REPORTS

Each standing and special committee of the Medical Staff shall periodically report its activities, findings, conclusions, recommendations, actions, and results of actions to the Medical Executive Committee. Each subcommittee shall periodically report its activities to the committee of which it is a part.

9.4.13 COMMITTEES AND DEPARTMENTS WITH PEER REVIEW RESPONSIBILITIES

Peer review is the concurrent or retrospective review of an individual's professional qualifications professional competence, or professional conduct, including through clinical professional review activities. Peer review or professional review activity is conducted to determine whether an individual may have Medical Staff membership or clinical privileges, to determine the scope and conditions of such membership or privileges, or to change or modify such membership or privileges.

9.4.13.1 Purpose of Peer Review: The purpose of the Hospital's peer review processes, programs, and proceedings is to encourage candid discussions in a private and confidential setting among Practitioners, other individuals with clinical privileges and other health care personnel to accomplish the following objectives:

9.4.13.1.1 To improve the quality of health care provided to patients;

9.4.13.1.2 To reduce morbidity and mortality at the Hospital;

9.4.13.1.3 To improve the credentialing process in an effort to monitor the competence, professional conduct and patient care activities of Practitioners, other individuals with clinical privileges, and other health care professionals who provide care to patients at the Hospital; and,

9.4.13.1.4 To maintain confidentiality of information generated during the course of peer review processes, programs and proceedings.

9.4.13.2 Peer Review Information: All peer review information shall be kept private and confidential. A Practitioner, other individual with clinical privileges, or other Hospital staff Member who participates or has participated in a peer review process at the Hospital shall treat all peer review information as private, confidential and privileged and shall not disclose peer review information obtained, generated or compiled during a peer review process in which he/she participates unless specifically and expressly authorized by the Hospital to do so or as required by law.

9.4.13.3 Hospital Committees or Functions: A peer review process includes any process, program or proceeding involving any or all of the following Hospital committees or functions: patient safety, performance improvement, utilization management, credentialing, infection control, review of use of operative and invasive procedures, review of medical records, review of use of medications, review of use of blood and blood components, clinical risk management, quality assessment, any other review or investigation of professional performance or conduct, and fair hearings and appeals conducted pursuant to the Medical Staff Fair Hearing Plan.

9.4.13.4 Circumstances for Peer Review: The primary purpose of peer review activities shall be to improve an individual's performance. Peer review analysis shall be conducted whenever data comparisons indicate that the level of an individual's performance patterns or trends vary substantially from the expected. Peer review shall also be conducted for unanticipated adverse events when root cause analysis indicates human factors related to an individual's performance are possibly significant to the cause of the event. Peer review may be conducted for other reasons including, but not limited to, situations involving an individual case that may fall outside the standard of care, or failure to comply with Hospital policies and procedures, or in any other circumstance deemed necessary by the President, President and CEO, Medical Executive Committee, or any other committee authorized to review of evaluate an individual's performance, or the Board of Trustees. An external reviewer or review panel may be used when the Medical Staff lacks necessary expertise, or when there is a question of conflict of interest, or when additional review is needed to confirm peer review results, or in any other circumstance in which external review is deemed necessary by the President, President and CEO, Medical Executive Committee, or any other committee authorized to review of evaluate an individual's performance, or the Board of Trustees.

9.4.13.5 Peer Review Panel: Peer review shall be conducted by a professional review body (e.g., a committee with a designated peer review function or an ad hoc peer review panel), any person acting as a Member or staff to a professional review body, or any person under contract with a professional review body. Ad hoc peer review panels may be selected for specific focused review by the President, President and CEO, Medical Executive Committee, any other Medical Staff committee authorized to review or evaluate care, or the Board of Trustees.

9.4.13.6 Timeframes for Review: Focused peer review activities shall be conducted and the results reports within a timeframe of 180 days. In circumstances requiring ongoing review before a determination can be made, an interim report may be submitted within the defined timeframe if the final report will not be completed within the defined timeframe.

9.4.13.7 Participation in Review: The individual whose performance or conduct is being reviewed shall have an opportunity to participate in the peer review process, either through attendance at a meeting in which the peer review results are discussed, in interviews with peer reviewers, or any other form of communication or correspondence with peer reviewers or the peer review panel. If the individual has been offered an opportunity to participate but the individual decides not to participate, the review may be concluded and final results reported without the participation of the individual.

9.4.13.8 Records and Minutes: The records and minutes of Medical Staff meetings and other Hospital committees and functions engaged in peer review shall be considered confidential. The commencement and completion of a peer review process will be documented; peer review processes that are continuous and ongoing will be identified. Peer review records and information will be identified with a conspicuous notation or stamp, for example: CONFIDENTIAL PEER REVIEW INFORMATION. The names of individuals who present or provide information during a peer review process should be documented.

9.4.13.9 Custody: Peer review information, including Medical Staff records, shall be maintained under the custody of the President and the President and CEO or their designee(s)

9.4.13.9.1 A Practitioner or other individual with clinical privileges shall be permitted access to further information in his or her own credentials and peer review file following a written request by the individual.

9.4.13.10 Medical Staff Officers: Members of the Board, licensing agencies, accreditation and regulatory authorities, the President and CEO, counsel to the Hospital, authorized Hospital staff members participating in utilization management functions or in performance improvement activities, may be afforded limited access to Medical Staff files and records, as appropriate. Medical Staff committee members who are members of the Medical Staff may have access to the records of committees on which they serve and to the applicable credentials, peer review, utilization management, and performance improvement files of individuals whose qualifications or performance the committee is reviewing as part of its responsibilities and official functions. The Board and the President and CEO and their properly designated representatives shall have access to Medical Staff records to the extent necessary to perform their responsibilities and official functions.

9.4.13.11 Outside Requests for Information: The Medical Staff Services and the President (or his designee) may release information contained in Medical Staff files in response to a proper request from another hospital or health care facility or institution, provided that the request includes a representation that the information shall be kept confidential. However, when the request seeks information considered to be privileged under the Kansas peer review and/or risk management statues, the information shall not be disclosed without first contacting the Hospital's risk Manager or legal counsel. The request must include information that the Practitioner or other individual with clinical privileges is a Member of the requesting facility's medical staff or has been granted privileges at the

requesting facility, or is an applicant for medical staff membership or clinical privileges at that facility, and must include a release for such records signed by the individual involved. No information shall be released until a copy of a signed authorization and release from liability has been received. Disclosure shall generally be limited to the specific information requested.

9.4.13.12 Reporting Obligations: If a Practitioner or other individual with clinical privileges has been the subject of disciplinary action at the Hospital and information concerning the action must be reported to the state professional licensing or regulatory authorities, appropriate information from Medical Staff files may be released for reporting and compliance purposes.

9.4.13.13 Surveyor Review: Hospital surveyors from licensing and regulatory agencies and authorities and accreditation bodies may be given access to Medical Staff records on the Hospital premises in the presence of Medical Staff personnel in accordance with law or accreditation requirements, provided that (a) no originals or copies may be removed from the premises, except pursuant to court or administrative order or subpoena or other legal requirements, (b) access is provided only with the concurrence of the President and CEO (or his/her designee) and the President (or his/her designee), and (c) the surveyor demonstrates the following to the satisfaction of the President and CEO or President:

9.4.13.13.1 Specific statutory, regulatory or other appropriate authority to review the requested materials;

9.4.13.13.2 The materials sought are directly pertinent to the matter being surveyed, investigated or evaluated;

9.4.13.13.3 The materials sought are the most direct and least intrusive means to accomplish the purpose;

9.4.13.13.4 Sufficient specificity of documents has been given to allow for the production of individual documents without undue burden to the Hospital;

9.4.13.13.5 If requests are made for documents with identifiers, the need for such identifiers is given and is determined to be appropriate, and information will be kept confidential to the maximum extent permitted by law.

9.4.13.14 Subpoenas: All subpoenas of Medical Staff records shall be referred to the President Director of Risk Management.

9.4.13.15 Legal Counsel: Legal counsel to the Hospital may have access to information in Medical Staff records related to peer review proceedings, litigation, potential litigation or threatened litigation.

9.4.13.16 Other Requests: All other requests by persons or organizations for information contained in Medical Staff records shall be provided to the Director of Risk Management who shall forward as appropriate.

9.4.13.17 Peer Review Meetings: All peer review functions shall be performed only at meetings held on the campus of the Hospital.

9.5 MEDICAL EXECUTIVE COMMITTEE

9.5.1 COMPOSITION

The Medical Executive Committee shall be composed of a majority of voting members who shall be fully licensed physician members of the Medical Staff actively practicing in the Hospital. The membership shall include the President, the President-Elect, the Immediate Past President, the Secretary/Treasurer, and the Chairpersons of each Medical Staff Department. The President and CEO, Chief Operating Officer, Chief Nursing Officer, and Vice President of Quality and Risk shall be ex-officio members without a vote. In addition, the Medical Staff representatives to the local medical societies will be ex-officio members without a vote. No Medical Staff Member actively practicing in the Hospital is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline, specialty, or practice as a hospital-based physician. The President shall serve as the chairperson of the committee.

9.5.2 DUTIES AND AUTHORITY

The Medical Executive Committee is empowered to represent and act for the Medical Staff in the interval between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws. The Medical Staff has delegated to the Medical Executive Committee the authority to adopt, on behalf of the voting members of the Medical Staff, any Rules and Regulations and Medical Staff Policies to address the details for describing, implementing, enforcing or otherwise operationalizing the provisions contained within these Bylaws. The Medical Executive Committee shall perform or direct the performance of the duties relative to the key functions of Governance and Planning, as described in these Bylaws in Sections 10.1.1 and 10.1.2, and oversee the performance of other key functions. To the extent of its monitoring and evaluating activities (e.g. the review of the quality and appropriateness of care), the Medical Executive Committee is established by the Board of Trustees as a peer review committee pursuant to KSA 65-4915 and shall comply with the Medical Staff Bylaws, Article 9.4.13 regarding peer review. The following duties shall be performed by the Medical Executive Committee:

9.5.2.1 Providing for current Medical Staff Bylaws, rules and regulations, and Medical Staff policies, subject to the approval of the Board.

9.5.2.2 Providing liaison and communication with all levels of Hospital governance and administration with regard to policy decisions affecting patient care services.

9.5.2.3 Collaborate with other leaders of the organization in Hospital planning.

9.5.2.4 Review the qualifications, evidence of current competence, and the recommendations of a Department Chairperson and the Credentials Committee for each individual applying for Medical Staff membership or clinical privileges, and make recommendations for appointment, reappointment, staff category, assignment to Departments, clinical privileges, and any disciplinary actions.

9.5.2.5 Organizing the Medical Staff's quality assessment and performance improvement activities and establishing a mechanism designed to conduct, evaluate, and revise such activities.

9.5.2.6 Conduct and supervise Medical Staff peer review activities.

9.5.2.7 Receive and act on reports and recommendations from Medical Staff committees, Departments, and assigned activity groups, specifically as

related to Medical Staff quality assessment and performance improvement activities.

9.5.2.8 Make recommendations directly to the Board with regard to all of the following:

9.5.2.8.1 The Medical Staff structure;

9.5.2.8.2 The mechanism used to review credentials and to delineate individual clinical privileges;

9.5.2.8.3 Recommendations of individuals for Medical Staff membership;

9.5.2.8.4 Recommendations for delineated clinical privileges for each eligible individual;

9.5.2.8.5 The participation of the Medical Staff in organization quality assessment, performance improvement, and patient safety activities;

9.5.2.8.6 Reports regarding the Medical Staff's evaluation of the quality of patient care services provided by the Medical Staff and the Hospital;

9.5.2.8.7 The mechanism by which Medical Staff membership may be terminated; and,

9.5.2.8.8 The mechanism for fair hearing procedures.

9.5.2.9 Report at each Medical Staff meeting with regard to the actions taken by the Medical Executive Committee on behalf of the Medical Staff.

9.5.2.10 The Executive Committee shall have the authority to determine the amount of annual dues or assessments, if any, for each category of Medical Staff membership subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds.

9.5.3 MEETINGS AND REPORTING

The Medical Executive Committee shall meet at least monthly, and shall report the activities of the Medical Staff and the Medical Executive Committee to the Board.

9.6 CREDENTIALS COMMITTEE

9.6.1 COMPOSITION

The Credentials Committee shall be composed of voting members who shall be active staff members in good standing. The voting membership shall include the President-Elect who shall chair the committee, the President, and the Chairpersons of each of the Medical Staff Departments. In addition to the President and CEO, the ex-officio members without vote shall also include a designated representative from the Medical Staff Services department.

9.6.2 DUTIES AND AUTHORITY

The Credentials Committee shall perform the key function of Credentialing, as described in these Bylaws in Section 10.1.3, under the oversight and direction of the Medical Executive Committee. The Credentials Committee shall review all applications for appointment, reappointment, and the granting, renewal or revision of clinical privileges and make

recommendations as to whether the applicants meet the Medical Staff's criteria for membership and/or clinical privileges. To the extent of its monitoring and evaluating activities (e.g. the review of the quality and appropriateness of care), the Medical Executive Committee is established by the Board of Trustees as a peer review committee pursuant to KSA 65-4915 and shall comply with the Medical Staff Bylaws, Article 9.4.13 regarding peer review. In addition, the following specific functions shall be performed by the Credentials Committee:

9.6.2.1 Oversee a mechanism to ensure that all Medical Staff members and individuals with clinical privileges maintain required credentials ongoing;

9.6.2.2 Through making recommendations related to granting clinical privileges, ensure that the same level of quality of care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;

9.6.2.3 Oversee a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted;

9.6.2.4 Make recommendations to the Medical Executive Committee with regard to any revisions in the process for appointment, reappointment or delineation of clinical privileges.

9.6.3 MEETINGS AND REPORTING

The Credentials Committee shall meet at least monthly, and shall report their recommendations and activities to the Medical Executive Committee.

9.7 OTHER COMMITTEES:

Please see Policy on Committees of the Medical Staff

10 ARTICLE TEN: MEETINGS

10.1 MEDICAL STAFF YEAR

The Medical Staff year shall be the period from January 1 through December 31 of each year.

10.2 MEDICAL STAFF MEETINGS

10.2.1 REGULAR MEETINGS

The annual meeting of the Medical Staff shall be held during the fourth quarter of the year, usually in November, at a time and place designated by the Medical Executive Committee, for the purpose of receiving reports from officers and committees, electing officers, and transacting other such business as may properly come before the meeting of the Medical Staff. The members shall hold two additional regular Medical Staff meetings throughout the year generally in January and May.

10.2.2 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at the direction of the President and shall be called by the President at the request of the Medical Executive Committee or any ten members of the active staff by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

10.3 DEPARTMENT MEETINGS

10.3.1 REGULAR MEETINGS

Regular meetings of each Department shall be held at least biannually, or more frequently as necessary to perform the functions of Departments as specified in Article Nine of these Bylaws.

10.3.2 SPECIAL MEETINGS

Special meetings of a Department may be called at the direction of the Chairperson of the Department and shall be called by the Chairperson or any three members of the active staff of the Department by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

10.4 ATTENDANCE REQUIREMENTS

10.4.1 GENERAL

Active staff members of the Medical Staff shall be encouraged to attend twenty-five percent (25%) of the meetings of the Department to which they are assigned, and the general staff meetings.

10.4.2 SPECIAL APPEARANCES

A Medical Staff Member or other individual with clinical privileges may be required to attend a meeting of a Medical Staff Committee for purposes of conducting peer review. Following receipt of proper notice of such an attendance requirement, failure to attend, unless excused by the presiding chairperson upon a showing of good cause, may be grounds for suspension, termination, or other actions on Medical Staff membership or clinical privileges.

10.5 MEETING PROCEDURES

10.5.1 NOTICE OF MEETINGS

Notice of the date, time and place of any Medical Staff meetings shall be given not less than seven (7) days prior to a meeting, and not less than three (3) days prior to a special meeting of the general Medical Staff by written notice delivered personally or sent by U.S. mail, electronic mail or facsimile, to each Member of the active staff at his/her preferred address as shown in Medical Staff records. The Medical Executive Committee or the President may send notice to members of other categories of the Medical Staff, the President and CEO, members of Administration and others. If mailed, notice shall be deemed to be delivered when deposited in the United States mail, postpaid.

Notice to a Medical Staff Member or other individual with clinical privileges who is being required to attend a meeting for quality review purposes shall be considered proper and valid when a registered, return receipt letter is sent at least seven (7) days prior to the meeting.

10.6 QUORUM

10.6.1 GENERAL STAFF MEETINGS

The presence of the active staff members present at any regular, special meeting, or for a special mailing shall constitute a quorum for the transaction of any Medical Staff business (with the exception of Bylaws as described in.12.2.1).

10.6.2 DEPARTMENT MEETINGS

The presence of the active Medical Staff members present at the meeting shall constitute a quorum at any meeting provided, however, that at least two (2) persons are present at any such meeting.

10.7 MANNER OF ACTION

The act of a majority of the voting members present at an annual or regular Medical Staff meeting at which a quorum is present shall be the act of the Medical Staff. The act of the majority of voting Department members present at a Medical Staff Department meeting at which a quorum is present shall be the act of the Department. Once a quorum has been established, all business on the agenda may be conducted, even if the quorum is lost, unless the number of yes votes and the number of no votes differ by only one (1) vote.

The Medical Executive Committee may authorize the submission of any Medical Staff matter to a vote by U.S. mail, facsimile, electronic mail, and/or in person by the individuals of the active medical staff, including revisions to these Bylaws, Rules and Regulations, and Policies. Ballots and other information deemed appropriate by the executive committee shall be provided to all members eligible to vote. Only ballots received by the medical staff office within ten (10) calendar days of the date that such ballots and other materials were disseminated to the medical staff shall be counted.

10.8 VOTING RIGHTS

Only active staff members have the right to vote.

10.9 RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Bylaws as ex-officio members of a Medical Staff body shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, and they shall not have voting rights unless expressly provided.

10.10 MINUTES

The Secretary/Treasurer shall prepare minutes of each meeting of the Medical Staff, which shall include a record of attendance and the vote taken on each matter. Minutes shall be signed by the Secretary/Treasurer, approved by the presiding officer, and maintained in a permanent file. Minutes shall be available for inspection by Medical Staff members for any proper purpose, subject to any policies concerning confidentiality of records and information. Each Department Chairperson shall ensure that minutes are prepared for their respective Department.

10.11 PROCEDURAL RULES

The President, or in his/her absence, the President-Elect, shall preside at general Medical Staff meetings. Meetings shall be conducted in accordance with an acceptable form of parliamentary procedure, such as Robert's Rules of Order, as may be modified by the Medical Staff.

11 ARTICLE ELEVEN: CONFIDENTIALITY, IMMUNITY AND RELEASE

11.1 AUTHORIZATIONS AND CONDITIONS

Any applicant for Medical Staff membership or clinical privileges and every Member of the Medical Staff or individual with clinical privileges shall agree that the provisions of this Article shall specifically control with regard to his/her relationship to the Medical Staff, other members of Staff, members of the Board, and the Hospital. By submitting an application for membership or clinical privileges, by accepting appointment or reappointment to the Staff or clinical privileges, or by exercising clinical privileges including temporary privileges, each individual specifically agrees to be bound by these Bylaws, including the provisions of this Article during the processing of his/her application and at any time thereafter, and such provisions shall continue to apply during his/her term of membership or term of clinical privileges.

11.2 CONFIDENTIALITY OF INFORMATION

Any act, communication, report, recommendation or disclosure concerning any applicant for membership or clinical privileges given or made by anyone in good faith and without malice, with or without the request of any authorized representative of the Medical Staff, the Administration, the Board, the Hospital or any other healthcare facility or provider for the purposes of providing, achieving or maintaining quality patient care in the Hospital or at any other healthcare facility shall be confidential and protected from discovery to the fullest extent permitted by law. Such protection shall extend to members of the Medical Staff, the President and CEO, Administrative officials, Board members and their representatives and to third parties who furnish information to any of them to receive, release or act upon such information. Third parties shall include individuals, firms, corporations and other groups, entities, or associations from whom information has been requested or to whom information has been given by a Member of the Medical Staff, authorized representatives of the Staff, the Administration or the Board.

11.3 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review, credentialing and quality assessment /performance improvement activities must be based on free and candid discussions, any breach of confidentiality of the discussions, deliberations, or records of any Medical Staff meeting, Department, or committee is outside appropriate standards of conduct for this Medical Staff and shall be deemed disruptive to the operation of the Hospital and as having an adverse impact on the quality of patient care. Such breach or threatened breach shall subject the individual responsible for a breach of confidentiality to disciplinary action under the Medical Staff Bylaws, Rules and Regulations, and applicable Hospital policies.

11.4 IMMUNITY FROM LIABILITY

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed, given or made, even if the information involved would otherwise be protected. No action, cause of action, damage, liability or expense shall arise or result from or be commenced with respect to any such act, communication, report, recommendation, or disclosure. Such immunity shall apply to all acts, communications, reports, recommendations and disclosures performed, given or made in connection with, or for, or on behalf of any activities of any other healthcare facility or provider including, without limitation, those relating to:

11.4.1 Applications for appointment to the Medical Staff or for clinical privileges;

11.4.2 Periodic appraisals or reviews for reappointment or for renewal or revisions to clinical privileges;

11.4.3 Corrective action or disciplinary action, including suspension or revocation of Medical Staff membership or clinical privileges;

11.4.4 Hearing and appellate review;

11.4.5 Medical care evaluations;

11.4.6 Peer review evaluations;

11.4.7 Utilization review and resource management; and,

11.4.8 Any other Hospital, departmental, service or committee activities related to quality patient care, professional conduct or professional relations. Such matters may concern, involve or relate to, without limitation, such person's professional qualifications, clinical competence, character, fitness to practice, physical and mental condition, ethical or moral standards or any other matter that may or might have an effect or bearing on patient care.

11.5 RELEASES

In furtherance of and in the interest of providing quality patient care, each applicant for Medical Staff membership or clinical privileges, and each Medical Staff Member or individual with clinical privileges shall, by requesting or accepting membership or clinical privileges, release and discharge from loss, liability, cost, damage and expense, including attorney's fees, such persons who may be entitled to the benefit of the privileges and immunities provided in this Article, and shall, upon the request of the Hospital or any officer of the Staff, execute a written release in accordance with the tenor and import of this Article.

11.6 SEVERABILITY

In the event any provision of these Bylaws are found to be legally invalid or unenforceable for any reason, the remaining provisions of the Bylaws shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

11.7 NONEXCLUSIVITY

The privileges and immunities provided in this Article shall not be exclusive of any other rights to which those who may be entitled to the benefit of such privileges and immunities may be entitled under any statute, law, rule, regulation, bylaw, agreement, vote of members or otherwise, and shall inure to the benefit of the heirs and legal representatives of such persons.

12 ARTICLE TWELVE: ADOPTION AND AMENDMENT AND GENERAL PROVISIONS

12 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Board of Trustees shall require the Medical Staff to adopt and enforce Bylaws to carry out its medical staff functions. The Board of Trustees shall require that the Medical Staff Bylaws, Rules & Regulations, and policies comply with local, State and Federal law and regulations, and the requirements of the Medicare hospital Conditions of Participation, and applicable accreditation standards. The Medical Staff Bylaws shall be adopted upon the approval of the Medical Staff and become effective upon approval by the Board. The Medical Staff Rules and Regulations and Policies shall be adopted upon the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and become effective upon approval by the Board. Medical Staff Rules and Regulations and Policies may contain the associated detail for provisions in the Medical Staff Bylaws. "Associated details" are the procedural steps necessary to describe, implement, enforce, or otherwise operationalize the provisions of the Bylaws.

The Medical Staff shall comply with and enforce the Medical Staff Bylaws, Rules and Regulations, and Policies and the Board of Trustees shall uphold the Medical Staff Bylaws that have been approved by the Board of Trustees.

12.1 EXCLUSIVE MECHANISM

The mechanism described herein shall be the sole method for initiation, adoption, amendment or repeal of the Medical Staff Bylaws.

12.2 METHODOLOGY

12.2.1 MEDICAL STAFF BYLAWS

12.2.1.1 Upon the request of the Medical Executive Committee, or the President, or the Bylaws Committee after approval by the Medical Executive Committee, or upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. If the proposed amendment, adoption or repeal is made by the Medical Executive Committee, the Medical Executive Committee shall first communicate the proposed amendment, adoption or repeal via written notice of the proposed change to all voting members of the Medical Staff no less than twenty (20) days prior to the date of dissemination of the written ballot as described below. If the proposed amendment, adoption or repeal is made by written petition of voting members of the Medical Staff, the Medical Staff members shall first communicate the proposal via written notice to all members of the Medical Executive Committee no less than twenty (20) days prior to the date of dissemination of the written ballot. The written notice shall include the exact wording of the existing Bylaws language, if any, and the proposed amendment.

12.2.1.2 Voting on a proposed amendment to the Bylaws shall occur only by written ballot disseminated by U.S. mail, electronically, or by facsimile to all Members eligible to vote. Before any proposed Bylaws amendment can be considered eligible for action, it shall first be required that at least 1/3 of the written ballots previously disseminated by US mail, electronically or by facsimile to all Members eligible to vote are properly executed and returned within ten (10) calendar days of the date of dissemination. If at least 1/3 of the ballots are so returned, then the proposed Bylaws change shall pass if there are at least 51% of the returned ballots in favor of the amendment.

12.2.1.3 In the event of a conflict within the Medical Staff regarding Medical Staff Bylaws, the Medical Staff process for conflict management shall be implemented. Bylaws changes adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be unreasonably withheld. Following significant changes to the Bylaws, Rules and Regulations or Medical Staff Policies, Medical Staff members shall be provided with a revised text.

12.2.1.4 In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with law or regulation or accreditation standards, the Medical Executive Committee may provisionally adopt, and the Board of Trustees may provisionally approve the urgent amendment without prior notification of the voting members of the Medical Staff. In such cases, the voting members of the Medical Staff shall be immediately notified by the Medical Executive Committee of the urgent amendment within ten (10) days after the Board of Trustees has approved the amendment. The voting members of the Medical Staff shall have an additional twenty (20) days within which to

retrospectively review the amendment and provide written comment to the Medical Executive Committee. If there are no comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then the Medical Staff process for conflict management shall be implemented, and a revised amendment shall be submitted to the Board of Trustees if necessary.

12.2.1.5 Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations, except as set forth below. As required by the Medicare Conditions of Participation and other regulatory requirements, the Board shall maintain complete and ultimate responsibility and authority over the Hospital and Medical Staff. In the event of a documented need for an urgent amendment of the Medical Staff Bylaws in which the Medical Staff and the Medical Executive Committee are incapable of, or refuse to amend the Medical Staff Bylaws to comply with local, State or Federal laws and regulations, or to address a documented concern that could adversely affect patient safety or quality of care, the Board shall exercise its authority in such a situation to unilaterally amend the Medical Staff Bylaws or Rules & Regulations as necessary to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital after first exhausting reasonable efforts to gain the Medical Executive Committee's or Medical Staff's approval, including using the conflict management process as set out below in Section. 12.4.9 In such a situation, the Board's amendment shall be final, and all voting members of the Medical Staff shall be notified of the amendment within ten (10) days of the amendment becoming final.

12.2.2 RULES & REGULATIONS AND MEDICAL STAFF POLICIES

To implement the Medical Staff Bylaws, the Medical Staff shall develop administrative procedures, which shall be described in documents that supplement the Bylaws, such as Rules and Regulations, and Policies.

12.2.2.1 Medical Staff Rules and Regulations and Policies: Subject to approval by the Board, the Medical Executive Committee, acting on behalf of the Medical Staff, shall adopt such Rules and Regulations and Policies as may be necessary to implement these Bylaws. The Medical Staff also has the ability to adopt Rules and Regulations and Policies and any amendments thereto by obtaining a written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote. The Rules and Regulations and Policies proposed by petition shall then be communicated to the Medical Executive Committee and shall be subject to final approval of the Board. The Rules and Regulations and Policies shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of each Staff appointee and individuals with clinical privileges. Such Rules and Regulations and Policies shall not conflict with the Governance Bylaws of the Board of Trustees.

12.2.2.2 Department Rules and Regulations and Policies: Subject to the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and the Board, each Department shall formulate its own Department Rules and Regulations and Policies for the conduct of its affairs and the discharge of its responsibilities. The members of the Department may also propose Department Rules and Regulations and Policies directly to the Board after first communicating the proposal to the Medical Executive Committee and such proposal shall be subject to final approval of the Board. Such Department Rules

and Regulations and Policies shall not be inconsistent with these Bylaws and the Rules and Regulations or Policies of the Medical Staff or other policies of the Hospital and shall not conflict with the Governance Bylaws of the Board of Trustees.

12.3 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee may correct typographical, spelling, grammatical or other obvious technical or editorial errors in the Bylaws and Rules and Regulations and Policies.

12.4 GENERAL PROVISIONS

12.4.1 SUCCESSOR IN INTEREST

These Bylaws and the membership accorded under these Bylaws will be binding upon the Medical Staff and the Board of any successor in interest in this Hospital except where hospital medical staffs are being combined. In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws which will govern the combined medical staffs, subject to the approval of the hospital's Board or its successor in interest. Until such time as the new bylaws are approved, the existing Bylaws of this Medical Staff shall remain in effect.

12.4.2 AFFILIATIONS

Affiliations between the Hospital and other hospitals, healthcare systems, or other entities shall not, in and of themselves, affect these Bylaws.

12.4.3 NO IMPLIED RIGHTS

Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy, or right of action upon any person, except as expressly set forth herein. These Bylaws and the Rules and Regulations are intended for internal Hospital use only and solely for the governance of the internal affairs of the Hospital. No person is authorized to rely on any provisions of these Bylaws or the Rules and Regulations except as specifically provided herein, and no person may personally enforce any provision hereof, except as specifically provided.

12.4.4 NOTICES

Any notices, demands, requests, reports or other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally, deposited in the United States first class mail, postpaid, electronically, or by facsimile to the person entitled to receive notice at his/her last known address, except as otherwise provided in these Bylaws or in the Rules and Regulations.

12.4.5 NO CONTRACT INTENDED

Notwithstanding anything herein to the contrary, it is understood that these Bylaws and the Rules and Regulations do not create, nor shall they be construed as creating, in fact or by implication or otherwise a contract of any nature between or among the Hospital or the Board or the Medical Staff and any Member of the Medical Staff or any person granted clinical privileges. Any clinical or other privileges are simply privileges which permit conditional use of the Hospital facilities, subject to the terms of these Bylaws and the Rules and Regulations.

Notwithstanding the forgoing, the provisions of Article Thirteen and other provisions containing undertakings in the nature of an agreement or an indemnity or a release shall be considered contractual in nature, and not a mere recital and shall be binding upon Medical Staff applicants and members and individuals applying for or those granted clinical privileges in the Hospital.

12.4.6 CONFLICT OF INTEREST

Individuals shall disclose any conflict of interest, as defined by the Board, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his/her participation on any committee or in his/her activities in Medical Staff affairs, including in departmental activities and in the review of cases. Where such a conflict of interest exists or may arise, the individual shall not participate in the activity, or as appropriate, shall abstain from voting. This provision does not prohibit any person from voting for himself/herself.

12.4.6.1 When performing a function outlined in the Bylaws, applicable policies, or the Rules and Regulations, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.

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

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

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

12.4.7 NO AGENCY

Physicians, other practitioners, and other individuals with clinical privileges shall not, by virtue of these Bylaws or Medical Staff appointment, be authorized to act on behalf of, or bind the Hospital, and shall not hold themselves out as agents, apparent agents or ostensible agents of the Hospital, except where specifically and expressly authorized in a separate written contract with the Hospital.

12.4.8 CONFLICT

In the event that these Bylaws, including provisions for Fair Hearing, shall conflict with the Rules and Regulations or the policies of the Medical Staff, the provisions of these Bylaws shall control.

12.4.9 CONFLICT MANAGEMENT/RESOLUTION

12.4.9.1 Conflicts Between The Board And The Medical Executive Committee: The Medical Staff, in partnership with the Board, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Board plans to act or is considering acting in a manner contrary to a recommendation made by the Medical Executive Committee, the Medical Staff officers shall meet with the Board, or a designated committee of the Board and Administration, and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the President or the Chairperson of the

Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Board-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

- Three officers of the Medical Staff
- One other Medical Executive Committee member
- The Chairperson, Vice-Chairperson, and Secretary of the Board or other designees of the Board
- The President and CEO or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Board within 30 days of the initial meeting, the Medical Staff and the Board shall enter into mediation facilitated by an outside party. The Medical Executive Committee and Board shall together select the third-party mediator, the costs for which shall be shared equally by the Hospital and the Medical Staff. The Medical Executive Committee and the Board shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Board and the Medical Executive Committee shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Board cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take provisional action that will remain in effect until the conflict resolution process is completed.

In addition to the formal conflict resolution process herein described, the Chairperson of the Board or the President may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Board, or Administration.

12.4.9.2 Conflicts Between The Medical Staff And The Medical Executive Committee: The Medical Executive Committee, as representatives of the Medical Staff, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Medical Executive Committee plans to act or is considering acting in a manner contrary to the wishes of the voting members of the Medical Staff, the Medical Staff shall present their recommendations to the Medical Executive Committee with a written petition signed by at least ten percent (10%) of the voting members of the Medical Staff. The Medical Staff officers shall meet with members of the Medical Staff representing the Medical Staff's recommendations as set forth in the petition and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the President, the representatives of the Medical Staff or the Chairperson of the Board may request

initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Medical Executive Committee-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

Three officers of the Medical Staff

Three voting members of the Medical Staff representing the recommendations in the written petition

The Chairperson of the Board

The President and CEO or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Medical Staff within 30 days of the initial meeting, the Medical Executive Committee and the Medical Staff shall enter into mediation facilitated by an outside party. The Medical Executive Committee and the three voting members of the Medical Staff representing the recommendations in the written petition shall together select the third-party mediator, the costs for which shall be paid in total by the Medical Staff. The Medical Executive Committee and Medical Staff shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Medical Executive Committee and the Medical Staff shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Medical Staff cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take provisional action that will remain in effect until the conflict resolution process is completed.

In addition to the formal conflict resolution process herein described, the Chairperson of the Board or the President may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Board, or Administration.

12.4.10 ENTIRE BYLAWS

These Bylaws are the entire Medical Staff Bylaws of the Hospital and supersede any and all prior Medical Staff Bylaws that, by adoption hereof, shall be automatically repealed.

CERTIFICATION OF ADOPTION AND APPROVAL

Approved and Adopted by the Medical Staff of Menorah Medical Center on November 10, 2014

PRESIDENT

Approved and Adopted by the Board of Menorah Medical Center on December 17, 2014.

CHAIRPERSON OF THE BOARD

DEFINITIONS/CONSTRUCTION OF TERMS AND HEADINGS

DEFINITIONS

The following terms shall have the meanings as set forth below, unless the context clearly indicates otherwise. Some of the terms defined below are not capitalized when used throughout these Bylaws.

Administration: The executive members of the Hospital staff, including the President and Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Nursing Officer (CNO).

Adverse Action: As provided in these Bylaws, means an action to restrict, suspend, revoke, deny or not renew a Practitioner's Medical Staff membership and/or clinical privileges, that is taken or made in the course of a professional review activity and is based on an evaluation of the Practitioner's clinical competence or professional conduct. An adverse action shall entitle the individual to the procedural rights described in Article Seven, except as provided in these Bylaws. This term is synonymous with "professional review action".

Advanced Practice Professional (APP): An individual, other than those defined under "Practitioner," who provides direct patient care services in the Hospital under a defined degree of supervision or collaboration (with the exception of a Ph.D.), exercising judgment within the areas of documented professional competence and consistent with applicable law. APPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges as either a dependent or independent healthcare professional as defined in these Bylaws. APPs are not eligible for Medical Staff membership. The Board has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), advanced registered nurse practitioner (ARNP), and clinical psychologists (Ph.D.).

There must be a supervision agreement (in the case of a PA) or a collaborative practice arrangement (in the case of ARNPs and CNMs). CRNAs are considered to practice interdependently within the physician health care team (see KSA 65-2258), although a collaborative practice arrangement is not required.

A licensed psychologist (doctoral prepared) may practice independently within the scope of his licensure.

Applicant: An individual who has submitted a Complete Application, as defined by these Bylaws, for appointment, reappointment or clinical privileges.

Board Certification or Board Certified: A designation for a physician or other practitioner who has completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that specialty and has maintained certification through retesting and completion of other maintenance of certification requirements. Board certification shall be from an American Board of Medical Specialties (ABMS) Member Board or from a Member Board of Certification of the Bureau of Osteopathic Specialists or from the American Board of Podiatric Surgery (ABPS) if the applicant is a podiatrist, or from the American Board of Oral/Maxillofacial Surgeons (ABOMS) if the applicant is an oral surgeon. ABMS is the umbrella organization for the 24 approved medical specialty boards in the United States. Member Boards determine whether candidates have received appropriate preparation in approved residency training programs in accordance with established educational standards, evaluate candidates with comprehensive examinations, and certify those candidates who have satisfied the board

requirements. The Bureau of Osteopathic Specialists was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. There are currently 18 AOA certifying boards. Each is titled, "American Osteopathic Board of (Specialty)." Podiatrists are certified through the American Board of Podiatric Surgery (ABPS) and oral surgeons are certified through the American Board of Oral/Maxillofacial Surgeons (ABOMS).

Board Certification Candidate: The status of a Practitioner who has successfully completed a residency or fellowship program for the Practitioner's specialty or subspecialty and is a candidate for board certification as determined by the American Board of Medical Specialties (ABMS) and/or the Practitioner's specific certifying board. The Board of Trustees may recognize other board certification programs at its discretion following a recommendation of the Medical Executive Committee and upon a showing that the program is substantially similar to those programs recognized by the ABMS, AOA, ABPS or ABOMS (as appropriate).

Board of Directors: The individuals elected by the shareholders for the Corporation (or selected or appointed by the Partnership) to hold ultimate responsibility for the Hospital and are the governing body of the Corporation (or Partnership), sometimes herein referred to as the "Directors."

Board of Trustees: As used herein, the Board of Trustees is the local governing body of the Hospital, delegated specific authority and responsibility, and appointed by the Board of Directors. It is the "governing body" as described in the standards of the Joint Commission and the Medicare Conditions of Participation. The Board of Trustees may also be referred to as the "Trustees" or the "Board" unless otherwise specifically stated.

Bylaws: The Bylaws of the Medical Staff, unless otherwise specifically stated.

Certification: The procedure and action by which a duly authorized body evaluates and recognizes (certifies) an individual as meeting predetermined requirements.

Clinical Privilege/Privilege: The permission granted by the Board to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, psychological, dental, or podiatry services with the approval of the Board.

Complete Application: An application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Medical Staff Department Chairperson, the Credentials Committee, the Medical Executive Committee and/or the Board to meet the requirements of these Bylaws. Specifically, to be complete the application must be submitted in writing on a form approved by the Medical Executive Committee and the Board, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant. Specific to applications or requests for clinical privileges, it shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the applicant meets the criteria for each of the privileges requested.

Conflict Management: The identification and use of techniques to effectively manage interpersonal, intra- and inter-group, and organizational conflicts. It requires impartiality, and use of negotiating and listening skills.

Contact: A patient "contact" is any admission, consultation, operation, emergency room visit or procedure on an inpatient or outpatient basis except that no more than one

"contact" will be considered for any patient for whom the Practitioner is the admitting or consulting physician.

Contract Practitioner: A Practitioner providing care or services to Hospital patients through a contract or other arrangement.

Corporation (or Partnership): The legal owner of the Hospital, **Midwest Division – MMC, LLC d/b/a/ Menorah Medical Center.**

CPC: HCA Credentials Processing Center

CPCS: The Clinical Patient Care System used to electronically document patient care.

Criminal Action: Conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.

Data Bank: The National Practitioner Data Bank (NPDB) implemented pursuant to the HCQIA.

Days: Calendar days, unless otherwise noted.

Dentist: An individual (DDS, DMD), who has received a doctor of dental surgery or a doctor of dental medicine degree from a dentistry program accredited by the Commission on Dental Accreditation (CODA) and has a current, unrestricted license to practice dentistry.

Dependent Healthcare Professional: An individual who is permitted both by law and by the Hospital to provide patient care services under the direction or supervision of an independent practitioner, within the scope of the individual's license or certification and in accordance with a Hospital-approved scope of practice.

Department: A clinical grouping of members of the Medical Staff in accordance with their specialty or major practice interest, as specified in these Bylaws.

Executive Committee/Medical Staff Executive Committee (MEC): The Medical Executive Committee of the Medical Staff, unless otherwise specifically stated.

Ex Officio: Service as a Member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

Fair Hearing Plan: The fair hearing plan as approved by the Medical Executive Committee and Board and incorporated into these Bylaws.

Federal Health Care Program: Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program). The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare and the Veterans programs.

FPPE: Focused Professional Practice Evaluation. See policy on Focused and Ongoing Professional Practice Evaluation.

Good Standing: The term "good standing" means a staff Member who, during the current term of appointment, has maintained all qualifications for Medical Staff membership, the assigned staff category, and been granted clinical privileges granted to the individual, and has met on-call and other participation requirements, is not in arrears in dues payment or the completion of medical records, is not currently the subject of a professional review activity, and has not received a limitation, suspension, or restriction of Medical Staff membership or privileges.

Governing Body: The Board of Trustees of the Hospital, which has been delegated specific authority and responsibility, and appointed by the Board of Directors.

GSA List: The General Service Administration's List of Parties Excluded from Federal Programs.

HCQIA: The Health Care Quality Improvement Act of 1986, 42 U.S.C.S. §11101 et seq.

Healthcare Professional: An individual licensed, certified, or registered by the State, or otherwise permitted, through virtue of completion of a course of study and possession of skills in a field of health, to provide health care to patients.

Hospital: Menorah Medical Center, 5721 W. 119th St., Overland Park, KS 66209. As the term is used in these Bylaws, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital, which is an organization inclusive of the Medical Staff.

Independent Healthcare Professional: An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges. Also referred to as a "Licensed Independent Practitioner".

Ineligible Person: Any individual who: (1) is currently excluded, suspended, debarred, or otherwise ineligible to participate in Federal health care programs; or (2) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible; or (3) is currently excluded on a state exclusion list.

License: An official or a legal permission, granted by a competent authority, usually public, to an individual to engage in a practice, an occupation or an activity otherwise unlawful.

License Status: Indicates the status of the practitioner's license, which is issued by the State licensure board. The categories defined by the State board are:

- active—full and unrestricted license to practice
- inactive—practitioner is not practicing, but reserves the right to activate their license in the future
- expired—no longer valid for use
- revoked—disciplinary action prohibits practice
- restricted —board imposed limitation on practice
- exempt—practitioner is not actively engaged in practice and does not hold himself as such but may serve as a coroner, as a paid employee of a local health department, or may practice as a charitable health care provider for an indigent health care clinic, or may perform administrative functions.
- military-active –practitioner is a member of the military

Licensure: A legal right that is granted by a governmental agency in compliance with a statute governing the activities of a profession.

Licensed Independent Practitioner (LIP): An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges. These are individuals who are designated by

the State and by the Hospital to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM).

Medical Staff: The Medical Staff is the term referring to the Practitioners designated by the Board to be eligible for Medical Staff membership and who are credentialed and privileged to provide professional healthcare services. The Board has determined that the categories of Practitioners eligible for Medical Staff membership are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM). The Medical Staff is an integral part of the Hospital and is not a separate legal entity.

Medical Staff Services: The Hospital employee(s) or contractor assigned the responsibility for processing applications for Medical Staff appointments, reappointments, and requests for clinical privileges, and for maintaining documents related to the credentialing process. Medical Staff Services responsibilities are assigned by Administration and the Hospital employee(s)/contractor who works in the Medical Staff Services is accountable to Administration. The documents maintained by the Medical Staff Services are the property of the Hospital.

Medical Staff, Organized: The Organized Medical Staff is the formally organized body of those individuals who, as a group, are responsible for establishing the bylaws and rules and regulations, and policies for the Medical Staff at large and for overseeing the quality of care provided by all Medical Staff members, as delegated by the Board of Trustees. The Organized Medical Staff is limited to Practitioners who are Medical Staff Members in the Active category of membership and have therefore been granted the rights to vote, to be a Member of a Medical Staff committee, and to hold office in the Organized Medical Staff.

Medical Staff Year: The period from January 1 through December 31 of each year.

Member: A Practitioner who has been granted and maintains Medical Staff membership and whose membership is in good standing pursuant to these Bylaws.

Membership: The approval granted by the Board to a qualified Practitioner to be a Member of the Medical Staff of the Hospital.

Non-Privileged Practitioner: Those individuals who are licensed to order specific tests and services but who are not medical staff members or practitioners with clinical privileges for practice within this Hospital.

OPPE: Ongoing Professional Practice Evaluation. See policy on Focused and Ongoing Professional Practice Evaluation.

OIG Sanction Report: The HHS/OIG List of Excluded Individuals/Entities.

Oromaxillofacial Surgeon Qualified: An individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA).

Peer: An individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications.

Peer Review: The concurrent or retrospective review of an individual's performance of clinical professional activities by peer(s) through formally adopted written procedures consistent with the Kansas peer review statute (KSA 65-4915) and/or the Kansas risk management statutes (KSA 65-4921 et seq.). With reference to Practitioners and Advanced Practice Professionals, written procedures for peer review are part of these Bylaws.

Physician: A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. [42 U.S.C. §1395x]

Podiatrist: A doctor of podiatric medicine (DPM) legally authorized to practice podiatry by the State in which he performs such function or action.

Practitioner/Licensed Independent Practitioner (LIP): See definition above for Licensed Independent Practitioner.

President: A Member of the active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital. The President shall be a doctor of medicine or osteopathy.

President and CEO: The individual appointed by Corporate Management to act on behalf of the Hospital in the overall management of the Hospital. In the event of his/her absence, the President and Chief Executive Officer may select a designee to temporarily serve in the role of administrator.

Privileges: Authorization granted by the Board to an individual to provide specific patient care services in the Hospital within defined limits, based on the individual's license, education, training, experience, competence, health status, judgment, individual character, and performance. Privileges shall be setting-specific, meaning that the privileges granted shall be based not only on the applicant's qualifications, but also a consideration of the Hospital's capacity and capability to deliver care, treatment, and services within a specified setting.

Proctor/Proctoring: Clinical proctoring is an objective evaluation of a Practitioner's actual clinical competence by a monitor or proctor who represents the Medical Staff and is responsible to the Medical Staff.

Professional Review Action: As provided in these Bylaws, means an action to reduce, restrict, suspend, revoke, deny or not renew a Practitioner's Medical Staff membership and/or clinical privileges, that is taken or made in the course of a professional review activity and is based on an evaluation of the Practitioner's clinical competence or professional conduct. This term is synonymous with "adverse action". An adverse action shall entitle the individual to the procedural rights afforded by the Fair Hearing Plan, except as provided in these Bylaws.

Professional Review Activity: As provided in these Bylaws, means a formal investigation or other activity of a professional review body with respect to a Member or Practitioner applicant to determine whether the Member or Practitioner applicant may have clinical privileges or Medical Staff membership; to determine the scope or conditions on such privileges or membership, or to change or modify such privileges or membership.

Professional Review Body: A committee, subcommittee or other body that engages in professional review activities for the purpose of furthering the delivery of quality healthcare. The designation of "Professional Review Body" includes but is not limited to any committee or subcommittee constituted to perform peer review activities as a component of its responsibilities, including the Board of Trustees.

Registration: The process in which a person licensed to practice by a federal or state authority has such a license recorded or registered.

Rules and Regulations: The Rules and Regulations of the Medical Staff including those of its Departments and Divisions as approved by the Medical Executive Committee and Board of Trustees.

Special Notice: Official notification to an individual sent in such a manner that proof of delivery to the addressee is received by the sender. For example: Registered Mail, Certified Mail, Federal Express, etc.

Staff: Unless otherwise specifically stated, the Medical Staff of this Hospital.

State: The State in which the Hospital operates and is licensed to provide patient care services, which is Kansas.

Telemedicine: Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Joint Commission and the American Telemedicine Association define telemedicine as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services.

Unprofessional or Inappropriate Conduct: Conduct which adversely impacts the operation of the Hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for hospital employees or other individuals working in the Hospital, or begins to interfere with the individual's own ability to practice competently. Such conduct may include disruptive, rude or abusive behavior or comments to staff members or patients, negative comments to patients about other physicians, nurses or other staff or about their treatment in the Hospital, threats or physical assaults, sexual harassment, refusal to accept medical staff assignments, disruption of committee or departmental affairs, or inappropriate comments written in patient medical records or other official documents.

CONSTRUCTION OF TERMS AND HEADINGS

All pronouns and any variations thereof in these Bylaws and Rules and Regulations shall be deemed to refer to the masculine, feminine, or neuter, singular or plural, as the identity of the person or persons may require, unless the context clearly indicates otherwise.

Planned Parenthood
Care. No matter what.

Planned Parenthood
Federation of America

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VIA EMAIL

January 17, 2017

Dear Mr. Langston:

As we noted in our correspondence of Friday January 13, 2017, we were waiting for further information from Menorah Medical Center ("Menorah") regarding Dr. Moore's privileges. We have now received information from Menorah that Dr. Moore has been reappointed to Menorah's staff with Associate/Affiliate privileges. Correspondence from the hospital, as well as the Delineation of Privileges for Dr. Moore, are attached hereto.

Please advise us within the next 7 days whether this information, and the information regarding Dr. Yeomans' privileges that we provided to you on Friday, changes DHSS's position, most recently expressed in your November 18, 2016 letter, as to whether Planned Parenthood is in compliance with the privileges requirement of the settlement agreement as to the Brous health center in Kansas City. As we mentioned in prior correspondence, the remaining items noted in your November 2, 2016 letter regarding the Brous center under the heading 19 CSR 30-30.0601(B)(8) require only minor adjustments to policies and practices around infection control which Planned Parenthood, as an experienced abortion provider, is prepared to quickly remedy once you have confirmed that our physician(s) have the appropriate privileges and that we can therefore move forward with the licensing process.

Thank you for your consideration.

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Sincerely,

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MENORAH MEDICAL CENTER
Medical Staff Services
5721 W 119th Street, Overland Park, KS 66209
(913) 498-6624 p | (913) 498-6648 f
www.menorahmedicalcenter.com

HCA MIDWEST HEALTH

December 21, 2016

Orrin A Moore, MD
4401 W 109th St, Suite 200
Overland Park, KS 66211

Dear Dr. Moore:

I am pleased to inform you that, upon the recommendation of the Medical Executive Committee, your reappointment to the Associate/Affiliate Medical Staff of Menorah Medical Center in the Department of Obstetrics and Gynecology, and the clinical privileges you requested were approved by the Board of Trustees of Menorah Medical Center at its 12/21/2016 meeting.

The Mid-America Division of HCA has developed a process to synchronize everyone's Medical Staff appointment expiration date to coincide with their month of birth. The goal is to streamline the credentialing process and require one application for providers who have privileges at multiple HCA Mid America Division facilities. This was approved by the Board in 2015.

At the end of the project, those born in an even year will be reappointed in an even year and those born in an odd year will be reappointed in an odd year. The expiration date will be the last day of your birth month. In order to transition you into the synchronized cycle your current reappointment expiration date has been adjusted. Your reappointment date is 1/1/2017 to 12/31/2018. This reappointment is for a period not to exceed twenty-four (24) months. At that time, upon application from you, your reappointment to the Medical Staff will be considered in accordance with the provisions in the Medical Staff Bylaws.

We thank you for your continued support of Menorah Medical Center and look forward to working with you. If we may be of any service to you, please don't hesitate to contact the Medical Staff Office at (913) 498-6625.

Sincerely,

Charles Laird
Chief Executive Office

Menorah Medical Center

Delineation of Privileges

Provider: Orrin A Moore, MD
ID: H2000052235
Status: Current
Category: Associate/Affiliate
Facility Status:

Privileges for: Obstetrics and Gynecology

Privilege	Status	Decision By	Original Date	Start Date	End Date	Condition
Colpotomy, Culdocentesis	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
I&D of abscess	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
Marsupialization or excision Bartholin Cyst/abscess	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
Biopsy of upper and lower genital tract	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
Cauterization of cervix	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
Amputation of cervix	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
Colposcopy	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
Colporrhaphy, anterior	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
Colporrhaphy, posterior	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
a. Cold-knife	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
c. LEEP	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
Dilatation and curettage, suction curettage	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
a. Vaginal	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
b. Abdominal	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
Laparotomy	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	
Salpingo-oophorectomy	Approved	Board of Trustees	03/23/2011	01/01/2017	12/31/2018	

EXHIBIT B

Boone Hospital New Provider Application Request *Note: Providers cannot start until notified they are credentialed.*	
Provider's Full Name & Title:	
Provider's Specialty:	
Provider's Anticipated Start Date:	
Is Provider to be a BHC Employee?	
Missouri License?	
Provider's Home Address:	
Provider's Home or Cell Number:	
Provider's SSN	
Provider's DOB	
Provider's NPI	
Provider's sex	
Provider's Email Address:	
Contact Name/Info, **if other than provider:**	
Sponsoring Physician (if applicable)	
Privilege Category: (Active, Courtesy, RMA, etc.)	
Practice Name:	
DBA:	
Practice Address:	
Practice Telephone Number:	
Practice Fax Number:	
Who will be providing emergency backup coverage? (must be current BHC staff)	
Malpractice Carrier (New Practice)	
ATTACH COPY OF CV TO EMAIL OR FAX (no processing will begin without a CV and specialty list attached)	

Below for Boone Medical Staff Services Use Only

Date Request Received:

Date Sent to CVO:

Revised: 1/28/15

Please return to BHC Medical Staff Services via fax at [redacted] or email at [redacted] along with a current CV.

BYLAWS, RULES AND REGULATIONS

of the

MEDICAL STAFF

BOONE HOSPITAL CENTER

Effective September 25, 2015

BYLAWS OF THE MEDICAL STAFF OF
BOONE HOSPITAL CENTER

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MEDICAL STAFF RULES AND REGULATIONS

PREAMBLE

These Bylaws, which originate with the Medical Staff, are adopted in order to provide for the organization of the Medical Staff of Boone Hospital Center and to provide a framework for self-regulation in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly achievement of those objectives.

These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants to and members of the Medical Staff. These Bylaws, when accepted and approved by the Board, create a system of mutual rights and responsibilities between members of the Medical Staff and the Hospital.

DEFINITIONS

Attending Practitioner means the physician (M.D. or D.O.) designated on the medical chart as having responsibility for the medical care and condition of the patient.

Board of Directors or Board means the governing body of CH Allied Services, Inc. d/b/a Boone Hospital Center.

Clinical Privileges or Privileges means the permission granted to a Practitioner or Affiliate to render specific services to patients and includes reasonable access to the Hospital resources (including equipment, facilities, and Hospital personnel) that are necessary to effectively exercise those Privileges, unless an exclusive contract exists between the Hospital and other physicians or a group practice with which the Practitioner is not affiliated.

Collegial Intervention means the use of progressive steps by the President and/or the Medical Staff, acting through a department, division, committee, or leader with authorization to do so as defined in the Medical Staff Bylaws and Rules and Regulations, to address issues relating to a Practitioner's professional performance, conduct or competence. The goal of Collegial Intervention is to resolve issues informally and voluntarily. Collegial Intervention is used when it is not anticipated that Corrective Action will be necessary.

Corrective Action means the process by which concerns about a Practitioner's professional performance, conduct or competence are subject to an investigation and adverse action (as defined in the Fair Hearing Plan) by the President, governing board, or Medical Staff, acting through a department, division, committee, or leader with authorization to do so as defined in the Medical Staff Bylaws and Rules and Regulations. Corrective Action is undertaken when matters are of such a serious nature that it is not believed that Collegial Intervention will be sufficient or when Collegial Intervention has been undertaken and these efforts have been unsuccessful.

Credentials File means the one file which shall serve as the credentialing record to be maintained on each Practitioner.

Department means a component of the Medical Staff consisting of Practitioners in similar areas of practice holding similar Clinical Privileges at the Hospital.

Division means a component of a Department of the Medical Staff consisting of Practitioners holding similar Clinical Privileges in a subspecialty.

Guests means persons attending a Medical Staff meeting who are not members of the Medical Staff.

Hospital means CH Allied Services, Inc. d/b/a Boone Hospital Center.

Medical Executive Committee or MEC means the Executive Committee of the Medical Staff.

Medical Staff or Staff means the formal organization of Practitioners who are granted Privileges by recommendation of the Medical Staff and approval of the Board.

Medical Staff Year means the period from January 1 to December 31.

Patient Contact shall mean each day on which a Practitioner provides inpatient or outpatient medical care and/or performs one or more procedures at the Hospital for a particular patient. Each patient for whom a Practitioner provides such medical care or procedures on a given day shall constitute a separate Patient Contact. Patient Contact shall not include ordering tests or procedures that are to be performed by other Practitioners or Hospital staff members.

Practitioner, unless otherwise expressly limited, means any physician (M.D. or D.O.), oral/maxillofacial surgeon, dentist or podiatrist duly licensed in Missouri, applying for or exercising Clinical Privileges in the Hospital.

President means the individual appointed directly by the Board who is responsible for the overall, day-to-day management of the Hospital.

Prerogative means a right granted, by virtue of Staff category or otherwise, to a Medical Staff member or Affiliate and exercisable subject to the conditions imposed in these Bylaws and Rules and Regulations and in other Hospital and Medical Staff policies.

Recognized Medical Affiliate or Affiliate means an individual other than a Practitioner who applies for and is granted permission by the Board to perform specified patient care services after review and recommendation by the Medical Executive Committee.

Regulation or Rule means a principle, directive, or guideline governing conduct, action, or procedure.

Special Notice means written notification delivered by messenger or sent, postage prepaid, via United States certified mail, return receipt requested.

Write or Written with respect to orders includes electronic entry and submission of orders via a computerized physician order entry system, in addition to handwritten orders.

ARTICLE I. NAME

1. The name of this organization shall be:

THE MEDICAL STAFF OF
BOONE HOSPITAL CENTER

ARTICLE II. PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the Medical Staff are:

A. to strive toward a pattern of patient care in the Hospital which is consistently maintained at a level of quality and efficiency consistent with the state of healing arts in the community and the resources locally available, and to serve as the primary means for accountability to the Board for the appropriateness of the professional performance and ethical conduct of Practitioners and Affiliates;

B. to establish a formal organization through which:

(1) the benefits of Medical Staff membership may be obtained by individual Practitioners; and

(2) the obligations of Medical Staff membership may be fulfilled;

C. to initiate and maintain rules for self governance of the Medical Staff; and

D. to provide a means through which the Medical Staff shall participate in the Hospital's policy making and planning process.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff are:

2.2-1 to account for the quality and appropriateness of patient care rendered by Practitioners and Affiliates organized to practice in the Hospital through maintaining the following:

A. A credentials program that establishes procedures for Medical Staff appointment and reappointment and the coordination of Clinical Privileges to be exercised and specified services to be performed by Practitioners;

B. A quality and appropriateness of care program which includes continuous, concurrent monitoring and evaluation of patient care practices and concurrent and/or retrospective review and evaluation of the quality of patient care; and

C. A continuing education program based in part on needs demonstrated through ongoing patient care evaluation programs.

2.2-2 to recommend action to the Board with respect to Medical Staff appointments, reappointments, Staff category, department, division and other assignments, Clinical Privileges, specified services for Staff and Affiliates, and corrective measures;

2.2-3 to advise the Board about the quality and efficiency of patient care in the Hospital by providing reports and recommendations concerning the implementation, operation and results of patient care monitoring and other quality accountability activities and services;

2.2-4 to initiate collegial intervention and pursue corrective action, as necessary, with respect to specific Practitioners;

2.2-5 to develop, administer, and seek compliance with the Medical Staff Bylaws, Rules and Regulations and applicable Medical Staff and Hospital policies, and the standards of regulatory agencies and accrediting bodies;

2.2-6 to assist in identifying community health needs and in establishing appropriate institutional goals and implementing programs to meet those needs; and

2.2-7 to exercise the authority granted by these Bylaws as necessary to discharge the foregoing responsibilities.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

No Practitioner, including one serving in a medical administrative position by reason of having a contract with or being employed by the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless he/she is a member of the Medical Staff or has been granted regular or temporary Privileges in accordance with the procedures set forth in these Bylaws and Rules and Regulations or applicable credentialing policies. Membership on the Medical Staff is not the right of any Practitioner. It is a privilege which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws and Rules and Regulations and applicable credentialing

policies. Appointment to the Medical Staff shall confer only such Clinical Privileges and Prerogatives as have been granted

3.2 BASIC QUALIFICATIONS FOR MEMBERSHIP

3.2-1 Basic Qualifications: To be eligible to apply for initial appointment and reappointment to the Medical Staff, a Practitioner must meet the requirements set forth in this Section and such other requirements as are established in accordance with these Bylaws. An application that does not include evidence of each of the following will not be considered complete and will not be processed. To be considered for membership and Clinical Privileges on the Medical Staff, a Practitioner must:

A. hold a valid and unrestricted license to practice in this state;

B. document his/her experience, background, training, and demonstrated ability to perform the Privileges requested sufficiently to demonstrate to the Medical Staff and the Board that any patient treated by the Practitioner will receive care of the generally recognized professional level of quality and efficiency;

C. have successfully completed one of the following:

(i) a residency training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the specialty in which the Practitioner seeks Clinical Privileges, except that an applicant who is in the final six months of a residency program may submit an application and be considered for appointment to the Medical Staff but final action on the application will not be taken until all eligibility criteria are satisfied;

(ii) an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association;

(iii) a dentistry program through an accredited dental school and have received a D.D.S. or equivalent degree; or

(iv) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

Notwithstanding the foregoing, a Practitioner who has not completed an approved residency training program as set forth in this Section may be considered for membership and Clinical Privileges on the Medical Staff if

the Practitioner meets all other requirements and the MEC and the President concur that allowing an exception would be consistent with particular patient care needs of the Hospital.

The requirements of this Section apply to Practitioners who seek initial appointment to the Medical Staff on or after the date the modifications are approved as set forth in ARTICLE XVI of these Bylaws.

D. be determined, on the basis of documented references, to adhere strictly to the ethics of his/her profession, to work cooperatively with others, and to be willing to participate in the discharge of Medical Staff responsibilities;

E. submit proof that he/she has met the requirements of Section 383.500, RSMo. (1986), regarding the holding of medical liability insurance and the Hospital's policy regarding professional liability insurance with a recognized insurance company authorized to do business in Missouri (which insurance shall be kept current as a condition of retention of Clinical Privileges);

F. where applicable, have a current, unrestricted DEA registration and state controlled substances license;

G. not be excluded from participation in the Medicare, Medicaid or other government payer program;

H. never have been convicted of, or entered a plea of guilty or no contest to any felony and, within the previous five (5) years, not have been convicted of, or entered a plea of guilty or no contest to any misdemeanor relating to controlled substances, illegal drugs, an act of violence, or insurance fraud;

I. not be seeking Clinical Privileges to treat medical conditions or patient populations for which the Hospital lacks necessary equipment, facilities or other resources or for which there is not a clinical need as determined by the Hospital administration; and

J. not be seeking Clinical Privileges that are subject to the terms of an exclusive contract between the Hospital and a physician group if the necessity for the arrangement has been subject to review by the MEC, unless the Practitioner is a party to or a beneficiary of the contract.

3.2-2 Effect of Other Affiliations. No Practitioner is automatically entitled to membership on the Medical Staff or to receive particular Clinical Privileges because he/she is licensed to practice in this or any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, Staff membership or

Privileges at another health care facility or in another practice setting, or because he/she has a contract to provide medical services at the Hospital.

3.2-3 Nondiscrimination. Medical Staff membership or particular Clinical Privileges shall not be denied on the basis of sex, age, race, creed, color, national origin or sexual orientation, or on the basis of any other criterion that is unrelated to quality of patient care in the Hospital, professional ability and judgment, and community need.

3.3 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Each member of the Medical Staff shall:

A. provide his/her patients with continuous care consistent with the standard of practice in the community and the generally recognized professional level of quality and efficiency;

B. comply with the Medical Staff Bylaws and Rules and Regulations, Hospital policies, federal and state statutes and regulations regarding patient care including, but not limited to, the provisions of EMTALA and other applicable ethical and accreditation standards;

C. cooperate with and discharge such Medical Staff, department, division, committee and Hospital functions for which he/she is responsible by appointment, election, or otherwise;

D. prepare and complete in a timely manner all medical and other required records for the Practitioner's patients, including a history and physical examination for each such patient as set forth in Article XV, Section 15.7 and Section B of the Rules and Regulations;

E. participate in continuing education activities as required for the Practitioner's continued licensure or for the Hospital's continued licensure or accreditation;

F. abide by the ethical principles of his/her profession as established from time to time by the American Medical Association, the American Osteopathic Association, the American Dental Association, or the American Podiatric Association, as applies;

G. work cooperatively with Practitioners, the Hospital administration and staff, and others and avoid disruptive behavior (*e.g.* engaging in physical aggression, sexual harassment or abuse; using threats, intimidation, or demeaning language), so as not to affect patient care adversely;

H. make appropriate arrangements for coverage for his/her patients as determined by Medical Staff Rules and Regulations and applicable credentialing policies;

I. participate in such emergency service coverage or consultation panels as may be required of members of the Staff by Medical Staff Bylaws and Rules and Regulations and Hospital policies that implement the requirements of federal and state law, including the Emergency Medical Treatment and Active Labor Act (EMTALA);

J. notify the Medical Executive Committee and Hospital administration promptly, and in all cases within thirty (30) days, of any actions that are taken against the Practitioner's professional license, certification, privileges or other credentials by any other hospital or health care facility, state licensure board, federal or state drug enforcement agency, or other federal or state governmental or administrative agency;

K. notify the MEC and Hospital administration within thirty (30) days of any malpractice settlement or judgment to which the Practitioner and/or his/her professional medical group is a party, specifically including any matter that must be reported to the Missouri Board of Healing Arts or the National Practitioner Data Bank;

L. work cooperatively with Medical Staff departments, divisions and committees in carrying out Staff functions, specifically including activities pertaining to quality assurance;

M. timely remit payment of Medical Staff dues and fees; and

N. discharge such other Medical Staff obligations as may be lawfully and reasonably established from time to time by the Medical Staff, MEC, Hospital administration or Board.

ARTICLE IV. CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The categories of the Medical Staff shall be Active, Senior Active, Courtesy, Consulting, Coverage, Community Affiliate and Honorary. The initial appointments of Practitioners to any of these categories, except Senior Active, Coverage, Community Affiliate or Honorary, will be Provisional appointments.

4.2 PROVISIONAL APPOINTMENTS

4.2-1 Requirements. Except as otherwise recommended by the MEC and approved by the Board, the initial appointments to any Staff category other than Senior Active

or Honorary shall be Provisional appointments for a period of one (1) year. The qualifications and responsibilities of Practitioners with Provisional appointments shall be consistent with those of other Staff members in that category, as set forth in the Medical Staff Bylaws and Rules and Regulations or applicable credentialing policies. Provisional appointees will have the same Prerogatives as other Staff members in that category, including those pertaining to attending Staff, department, division, and committee meetings, except that Provisional appointees may not vote or hold office on the Medical Staff or in a department, division or Staff committee.

4.2-2 Procedures. Each Provisional appointee shall be assigned to an appropriate department. The department chief and his/her designees in the department shall review and assess the Practitioner's clinical competence, professional performance, and eligibility to be awarded regular membership on the Medical Staff in the category and with the Clinical Privileges that have been Provisionally granted to the Practitioner. This assessment will be based in part on procedures established by the MEC, including standards that are intended to regularly verify the Practitioner's eligibility to be granted and to exercise the Clinical Privileges that have been awarded to him/her on a Provisional basis. At least sixty (60) days prior to the end of a Practitioner's Provisional appointment, the chief of the department will provide a written recommendation to the Credentials Committee as to whether the Provisional appointee should be granted regular membership on the Medical Staff and the Clinical Privileges that have been Provisionally granted. Whether a Provisional appointee will be granted regular membership and specific Clinical Privileges on the Medical Staff will depend, in part, on the recommendation of the department chief.

4.2-3 Extension of Provisional Appointment. The Provisional appointment of a Practitioner may be extended for a period of up to six (6) months upon the recommendation of the MEC and the concurrence of the Board.

4.2-4 Relinquishment of Privileges or Termination of Provisional Appointment. At the end of a Provisional appointment, if a Practitioner does not meet eligibility standards established by the MEC for being granted specific Clinical Privileges that have been awarded on a Provisional basis, those Privileges will be subject to automatic relinquishment and this will not be considered an adverse action under the Medical Staff Bylaws and Rules and Regulations. If the MEC finds that there is not sufficient evidence that the Practitioner demonstrates the clinical competence, professional performance, or other qualifications to be granted regular membership on the Medical Staff and the Clinical Privileges that have been requested, then the Practitioner's Provisional appointment will be subject to termination upon the recommendation of the MEC and the approval of the Board. The MEC's recommendation will be considered an adverse action to which the procedural rights set forth in the Medical Staff Bylaws and Rules and Regulations will apply.

4.3 ACTIVE STAFF

4.3-1 Qualifications. The Active Staff shall consist of Practitioners, each of whom:

A. meets the basic qualifications set forth in Section 3.2-1;

B. resides or will be located so as to be able to provide continuous care to his/her patients admitted to the Hospital and to respond within thirty (30) minutes or such lesser period as is required by law, in person or by phone, when the Practitioner is on call; and

C. regularly admits patients to, or is otherwise regularly involved in Patient Contact at the Hospital and has successfully completed at least one (1) year of a Provisional appointment as described in Section 4.2 above.

4.3-2 Prerogatives. The Prerogatives of an Active Staff member shall be to:

A. admit patients to the Hospital as follows:

(i) a physician (M.D. or D.O.) member may admit without limitation;

(ii) oral/maxillofacial surgeons may admit patients for oral or maxillofacial surgery and may perform history and physical examinations on such patients and assess the risk of proposed surgery in accordance with the scope of their Clinical Privileges. Consultation with an attending physician shall be obtained as appropriate or upon the request of the attending anesthesiologist for medical appraisal and management of any medical problem present at admission or arising during hospitalization;

(iii) dentist or podiatrist members shall be under the jurisdiction of the Chief of Surgery and may admit patients, provided it is demonstrated at the time of admission and at all times thereafter, that an attending physician has assumed responsibility for the basic medical appraisal and condition of the patient and for the care of any medical problem present at admission or arising during hospitalization;

B. exercise such Clinical Privileges as are granted to him/her;

C. attend general and special meetings of the Medical Staff and of the department, division and committees of which he/she is a member and vote (except during periods when his/her Medical Staff status is Provisional) on matters presented at these meetings; and

D. hold office on the Medical Staff and in the department, division and committees of which he/she is a member (except during periods when Staff status is Provisional), except that Staff members with dental and podiatric Privileges shall not be eligible to hold office.

4.3-3 Responsibilities. Each member of the Active Staff shall:

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

B. retain responsibility within his/her defined Privileges for the daily care and supervision of each patient in the Hospital for whom he/she is providing medical services, or make arrangements for another qualified Practitioner to assume responsibility for such care and supervision;

C. actively participate in the patient care monitoring and other quality assurance activities required of the Staff in supervising peers with Provisional status and in discharging such other Medical Staff functions as may from time to time be required;

D. satisfy the requirements for attendance at meetings of the Medical Staff and the department, division, and committees of which he/she is a member; and

E. satisfy such other requirements as pertain to his/her appointment or reappointment, including those that apply to the minimum Patient Contact needed for a Practitioner with these Privileges.

If, during any two year period of appointment to the Active Staff, a Practitioner has had minimal or no Patient Contact at the Hospital as determined by the MEC and/or has not participated in Medical Staff functions as required by the Medical Staff Bylaws and Rules and Regulations, then the Practitioner will not be eligible to apply for reappointment to the Active Staff for at least one (1) year. The Practitioner may apply for Privileges in another category of the Medical Staff for which he/she is eligible.

4.4 SENIOR ACTIVE STAFF

4.4-1 Qualifications. The Senior Active Staff shall consist of Practitioners, each of whom:

A. meets the basic qualifications set forth in Section 3.2-1;

B. resides or will be located so as to be able to provide continuous care to his/her patients admitted to the Hospital and demonstrates that he/she will be able to respond within thirty (30) minutes or such lesser period as is required by law, in person or by phone, if the Practitioner is asked to

assume the responsibilities of Active Staff membership by taking call from time to time, as set forth in Section 4.4-3A(i);

C. regularly admits patients to, or is otherwise regularly involved in Patient Contact at the Hospital;

D. has been a member in good standing of the Active Staff; and

E. meets one of the following requirements:

(i) he/she has reached the age of sixty-five (65), or

(ii) he/she has completed at least thirty (30) years of service on the Medical Staff.

If a member of the Active Staff applies for Senior Active status for any other reason, including reasons relating to health, then the MEC will have the discretion to decide whether to recommend to the Board that the requested change in Staff category should be granted.

4.4-2 Prerogatives. The Prerogatives of a Senior Active Staff member shall be to:

A. admit patients to the Hospital, consistent with the Prerogatives of Active Staff members, as set forth in Section 4.3-2A;

B. exercise such Clinical Privileges as are granted to the Practitioner;

C. attend general and special meetings of the Medical Staff and of the department, division and committees of which he/she is a member and vote on matters presented for consideration at these meetings; and

D. hold office on the Medical Staff and in the department, division and committees of which he/she is a member, except that Medical Staff members with dental and podiatric Privileges shall not be eligible to hold office.

4.4-3 Responsibilities. Each member of the Senior Active Staff shall:

A. meet the basic responsibilities set forth in Section 3.3, except that Senior Active Staff members shall not be required to:

(i) participate in Emergency Department call unless there is a temporary shortage in the Practitioner's specialty, in which case the Practitioner may be expected to assume call from time to time as requested by the MEC and President;

(ii) pay Medical Staff dues; or

(iii) attend Medical Staff, department, division or committee meetings;

B. retain responsibility within his/her defined Privileges for the daily care and supervision of each patient in the Hospital for whom he/she is providing medical services, or make arrangements for another qualified Practitioner to assume responsibility for such care and supervision; and

C. actively participate in the patient care monitoring and other quality assurance activities required of the Staff in supervising peers with Provisional status and satisfying such other requirements as pertain to his/her appointment or reappointment, including those that apply to the minimum Patient Contact needed for a Practitioner with these Privileges.

If, during any two year period of appointment to the Senior Active Staff, a Practitioner has had minimal or no Patient Contact at the Hospital as determined by the MEC, then the Practitioner will not be eligible to apply for reappointment to the Senior Active Staff for at least one (1) year. The Practitioner may apply for Privileges in another category of the Medical Staff for which he/she is eligible.

4.5 COURTESY STAFF

4.5-1 Qualifications. The Courtesy Staff shall consist of Practitioners, each of whom:

A. meets the basic qualifications set forth in Section 3.2-1;

B. resides or will be located so as to be able to provide continuous care to his/her patients admitted to the Hospital and demonstrates that he/she will be able to respond within thirty (30) minutes or such lesser period as is required by law, in person or by phone, if the Practitioner is asked to assume the responsibilities of Active Staff membership by taking call from time to time, as set forth in Section 4.5-3A(i);

C. has successfully completed at least one (1) year of a Provisional appointment as described in Section 4.2 above; and

D. has up to ten (10) Patient Contacts per Medical Staff Year.

4.5-2 Prerogatives. The Prerogatives of a Courtesy Staff member shall be to:

A. admit patients to the Hospital as set forth in Section 4.3-2A, within the limitations provided in Section 4.5-1C above. At times of full Hospital occupancy or of shortage of Hospital beds or other facilities as determined by the President, the admitting Privileges of Courtesy Staff members shall

be subordinate to those of Active Staff members, except as pertains to patients with emergent conditions;

B. exercise such Clinical Privileges as are granted to him/her;

C. attend meetings of the Medical Staff and the department, division and committees of which he/she is a member and have the Prerogatives of the floor but not hold office or vote on matters presented for consideration at these meetings; and

D. attend meetings of the Medical Staff committees of which he/she is a member, have the Prerogatives of the floor, and vote on matters brought before these committees but not serve as chair of any such committees.

4.5-3 Responsibilities. Each member of the Courtesy Staff shall:

A. meet the basic responsibilities set forth in Section 3.3, except that Courtesy Staff members shall not be required to:

(i) participate in Emergency Department call unless there is a temporary shortage in the Practitioner's specialty, in which case the Practitioner may be expected to assume call from time to time as requested by the MEC and President; or

(ii) attend Medical Staff, department, division, or committee meetings;

B. retain responsibility within his/her defined Privileges for the daily care and supervision of each patient in the Hospital for whom he/she is providing medical services, or make arrangements for another qualified Practitioner to assume responsibility for such care and supervision; and

C. actively participate in the patient care monitoring and other quality assurance activities required of the Staff in supervising peers with Provisional status and satisfy such other requirements as pertain to his/her appointment or reappointment, including those that apply to the minimum Patient Contact needed for a Practitioner with these Privileges.

If a Practitioner has in excess of the number of Patient Contacts that are allowed for Courtesy Staff members, then the Practitioner will be notified of this. The Practitioner may either (i) request a modification of his/her Privileges to Active Staff or another category for the remainder of the period of appointment, (ii) decide not to admit additional patients for such time as is necessary to allow him/her to be in compliance with the Bylaws for Courtesy Staff members, or (iii) relinquish his/her Medical Staff membership and Privileges. If, during any two year period of appointment to the Courtesy Staff, a Practitioner has had no Patient Contact at the Hospital as determined by the MEC, then the Practitioner will not

be eligible to apply for reappointment to the Courtesy Staff for at least one (1) year unless he/she presents data pertaining to his/her professional practice in another inpatient or outpatient setting during the previous two years that is sufficient to enable the Hospital to meet Joint Commission requirements for the ongoing credentialing of physicians. If the Practitioner fails to provide such data, then his/her application will be considered incomplete and it will not be processed. However, the Practitioner may apply for Privileges in another category of the Medical Staff for which he/she is eligible.

4.6 CONSULTING STAFF

4.6-1 Qualifications. The Consulting Staff shall consist of Practitioners, each of whom:

A. meets the basic qualifications set forth in Section 3.2-1;

B. has outstanding training and/or experience in a medical specialty or subspecialty and devotes himself/herself to that specialty;

C. presents evidence in writing of an invitation by one (1) or more members of the Active or Senior Active Staff or the President to provide consulting services at the Hospital in that medical specialty or subspecialty because there is a need for the consultant's services and there are no other Practitioners on the Medical Staff with Clinical Privileges in that specialty or subspecialty who have appropriate expertise and are willing to provide particular services;

D. is willing and able to provide occasional consulting services in that medical specialty, on a predetermined schedule or when requested by another Practitioner to provide these services;

E. is a member of the Medical Staff of one or more licensed hospitals in the State of Missouri or in another state where he/she is subject to performance improvement activities similar to those required of members of the Medical Staff, except that exceptions to this requirement may be allowed for good cause, consistent with the nature of the services that are to be provided and particular patient care needs of the Hospital as determined by the MEC and President; and

F. has successfully completed at least one (1) year of a Provisional appointment as described in Section 4.2 above, with verification of the continued need for the Consultant's services in accordance with Section 4.6-1 C above. If the MEC, in consultation with the referring Practitioner and/or the President, determines that there is not a continued need for the Consultant's services, then the President will provide written notice to the Practitioner that he/she will not be eligible to be awarded full Consulting Staff privileges and that the Practitioner's privileges will lapse.

Appointment to the Consulting Staff is a courtesy that may be denied or terminated by the Board upon recommendation of the MEC, without rights to a hearing or appeal. The Practitioner may apply for Clinical Privileges in another category of the Medical Staff for which he/she is eligible.

4.6-2 Prerogatives. The Prerogatives of a Consulting Staff member shall be to:

A. act as a consultant in his/her medical specialty upon the request of a member of the Medical Staff or the President but not admit patients to the Hospital;

B. exercise such Clinical Privileges as are granted to him/her pursuant to the Medical Staff Bylaws and Rules and Regulations or applicable credentialing policies; and

C. attend meetings of the Medical Staff and the department, division and committees of which he/she is a member, but not to have the Prerogatives of the floor, or to vote or hold office.

4.6-3 Responsibilities. Each member of the Consulting Staff shall:

A. meet applicable basic responsibilities of Medical Staff membership as set forth in Section 3.3, except that Consulting Staff members shall not be required to:

(i) participate in Emergency Department call; or

(ii) attend Medical Staff, department, division, or committee meetings; and

B. reasonably respond to requests to provide consulting services in his/her specialty as set forth in Section 4.6-1 D.

If a member of the Consulting Staff does not provide any consulting services regarding the medical needs of patients of the Hospital for two (2) consecutive two (2) year periods of appointment to the Medical Staff as determined by the MEC, then the Practitioner shall not be eligible to apply for reappointment as a member of the Consulting Staff for at least one (1) year unless there is verification of a need for the Practitioner's services as set forth in Section 4.6-1 above. Appointment to the Consulting Staff is a courtesy that may be denied or terminated by the Board upon recommendation of the MEC, without rights to a hearing or appeal. The Practitioner may apply for Clinical Privileges in another category of the Medical Staff for which he/she is eligible.

4.7 COVERAGE STAFF

4.7-1 Qualifications. The Coverage Staff shall consist of Practitioners, each of whom:

A. meets the basic qualifications set forth in Section 3.2-1;

B. has successfully completed at least one (1) year of a Provisional appointment as described in Section 4.2 above;

C. is a member in good standing of the Active Staff of another hospital (unless this requirement is waived by the Board after considering the recommendations of the Credentials Committee and the MEC);

D. seeks appointment to the Medical Staff solely for the purpose of providing coverage assistance in his/her medical specialty on behalf of one or more Practitioners on the Active or Senior Active Staff who are members or affiliates of the same physician practice; and

E. presents written confirmation from either one (1) or more such Practitioners or the President of the need for coverage in the Practitioner's specialty or subspecialty. The grant of appointment as a Coverage Staff member is a courtesy that may be denied or terminated by the Board upon recommendation of the MEC, without rights to a hearing or appeal.

4.7-2 Prerogatives. The Prerogatives of a Coverage Staff member shall be to:

A. admit and treat patients when providing coverage assistance for an Active or Senior Active Staff member and the Practitioner assumes responsibility for the medical care of patients who are or would be the responsibility of that Active or Senior Active Staff member;

B. exercise such Clinical Privileges as are granted to him/her; and

C. attend meetings of the Medical Staff and the department, division and committees of which he/she is a member and have the Prerogatives of the floor but not hold office or vote on matters presented for consideration at these meetings.

4.7-3 Responsibilities. Each member of the Coverage Staff shall:

A. meet the basic responsibilities set forth in Section 3.3, except that Coverage Staff members shall not be required to:

(i) participate in Emergency Department call except when the Practitioner is providing coverage assistance for another Active or Senior Active Staff member, as described in Section 4.7-2 above;

(ii) attend Medical Staff, department, division, or committee meetings; or

(iii) meet eligibility criteria pertaining to residency or the location of their clinical offices.

B. retain responsibility within his/her defined Privileges for the daily care and supervision of each patient for whom he/she is providing medical services in accordance with Section 4.7-2, including emergency services and care for unassigned patients; and

C. provide evidence of clinical performance in such form as may be required by the MEC, the Credentials Committee or the department of which he/she is a member, in order to allow for an appropriate assessment of the Practitioner's continued qualifications for initial appointment or reappointment and Clinical Privileges.

If a member of the Coverage Staff does not provide any medical services at the Hospital for a two (2) year period of appointment to the Medical Staff as determined by the MEC, then the Practitioner shall not be eligible to apply for reappointment as a member of the Coverage Staff for at least one (1) year unless there is a verification of a need for the Practitioner's services as set forth in Section 4.7-1 above. Appointment to the Coverage Staff is a courtesy that may be denied or terminated by the Board upon recommendation of the MEC, without rights to a hearing or appeal. The Practitioner may apply for Privileges in another category of the Medical Staff for which he/she is eligible.

4.8 COMMUNITY AFFILIATE STAFF

4.8-1 Qualifications. The Community Affiliate Staff shall consist of Practitioners who do not seek or intend to maintain an inpatient practice, each of whom:

A. meets the basic qualifications set forth in Section 3.2-1(A), (E), (G) and (H); and

B. seeks to be associated with the Hospital to access medical services on behalf of his/her patients and to enjoy the professional, educational, and collegial opportunities offered by the Hospital. The grant of appointment as a Community Affiliate Staff member is a courtesy extended to a Practitioner that may be declined or terminated by the Board upon recommendation of the MEC, without rights to a hearing or appeal.

4.8-2 Prerogatives and Responsibilities. The Prerogatives of a Community Affiliate Staff member shall be to:

A. be a member of the Medical Staff but not have Clinical Privileges entitling the Practitioner to admit patients or provide medical services at the Hospital;

B. attend educational programs and meetings of the Medical Staff and have the Prerogatives of the floor but not hold office or vote on matters presented for consideration at these meetings;

C. refer patients to members of the Medical Staff for admission and medical treatment, including the use of Hospital's diagnostic facilities; and

D. review medical records and test results of the patients whom the Practitioner has referred to the Hospital and submit relevant outpatient records of these patients for inclusion in the Hospital's medical record.

4.9 HONORARY STAFF

4.9-1 Qualifications. The Honorary Staff shall consist of Practitioners who are recognized for their outstanding reputation, noteworthy contributions to the health and medical sciences, or previous long standing service at the Hospital, including Practitioners who have been members in good standing of the Active or Senior Active Staff who have retired from medical practice.

4.9-2 Prerogatives/Responsibilities. Honorary Staff members shall not be eligible to admit patients or to exercise Clinical Privileges in the Hospital. The Prerogatives of an Honorary Staff member shall be to attend Medical Staff and department and division meetings and other Medical Staff functions. Honorary Staff members shall not be eligible to vote or hold office on the Medical Staff or in a department or division or to exercise other Prerogatives of Medical Staff membership, except that Honorary Staff members may be appointed to serve on committees of the Medical Staff and to have voting rights on those committees.

4.10 FELLOWS, RESIDENTS AND INTERNS

4.10-1 Circumstances and Qualifications. Fellows, residents or interns who wish to use the Hospital as a clinical training site may be permitted to provide medical services at the Hospital with the sponsorship of one or more members of the Active Staff or Consulting Staff, and if there is an affiliation agreement in effect between the Hospital and the medical school or other institution at which the fellow, resident or intern is receiving training. Fellows, residents or interns who may be approved to provide services in these circumstances shall consist of physicians who have registered with the Hospital in accordance with applicable procedures, who are licensed to practice in the State of Missouri, who are in a

fellowship, residency or internship training program approved by the Hospital and applicable clinical departments, who satisfy the requirements of Section 3.2-1 as applicable, and who desire to utilize Boone Hospital Center as a clinical training site.

4.10-2 Prerogatives. Fellows, residents and interns who seek to use the Hospital as a training site may treat patients only under the consenting authority of one (1) or more Active Staff or Consulting Staff members with Privileges in the area in which the fellow, resident or intern seeks clinical training, who are present in the community and who shall be fully responsible at all times for any patients seen by the fellow, resident or intern being sponsored, and who shall countersign all orders within 24 hours. Fellows, residents or interns in training shall not hold appointments to the Medical Staff and shall not be eligible to vote, to hold office, or to be members of any Medical Staff department, division or committees.

4.10-3 Responsibilities. Fellows, residents and interns in training shall have such responsibilities as are determined by the sponsoring Practitioner in accordance with an affiliation agreement between the Hospital and the training institution and/or applicable policies and protocols of the Hospital, and as may be determined from time to time by the Medical Executive Committee. A Practitioner must accept responsibility for the services of any fellow, resident or intern to whom he/she wishes to provide training, as follows:

A. The Practitioner must agree to provide continuous, direct oversight of the fellow, resident or intern as to all Patient Contact he/she has in the Hospital;

B. The Practitioner must assume responsibility for the medical care of any patient who receives treatment while a fellow, resident or intern is being trained by that Practitioner;

C. The Practitioner must insure that a patient who receives treatment while an fellow, resident or intern is being trained by that Practitioner has been informed and has consented to the participation of the fellow, resident or intern; and

D. A Practitioner may not provide training to more than two (2 fellows, residents or interns within any period of time.

4.10-4 Notice. A fellow, resident or intern in training may not begin to provide services or have any Patient Contact at the Hospital until and unless he/she has received Special Notice from the President that his/her application to receive training has been approved.

4.11 LIMITATION OF PREROGATIVES

The Prerogatives set forth in each Medical Staff category are general in nature and may be subject to limitation or expansion by special conditions attached to the Practitioner's Staff membership as set forth in or adopted in accordance with the Medical Staff Bylaws and Rules and Regulations or applicable credentialing policies.

4.12 WAIVER OF QUALIFICATIONS

Any qualifications, except the Basic Qualifications set forth in Section 3.2-1 and the Particular Qualifications set forth in Section 3.3, may be waived or modified in the discretion of the Board upon recommendation of the Medical Executive Committee and a determination that such waiver will serve the best interests of patients and the Hospital.

4.13 LEAVE OF ABSENCE

4.13-1 General. A Medical Staff member may apply to the MEC for a leave of absence of a specified duration, generally not to exceed six (6) months, during which time he/she shall be excused from assuming and exercising the responsibilities and rights of Medical Staff membership, including admitting patients, taking call and participating in Staff, department, division, and committee meetings and functions. A leave of absence shall not alter or extend such Practitioner's current term of appointment, except as provided herein.

4.13-2 Inability to Exercise Privileges. If a Practitioner is unable or will be unable to exercise his/her Clinical Privileges for a period of forty five (45) days or more for any reason, then he/she must request a leave of absence. In the absence of such a request, if the MEC learns that a Practitioner has been or will be unable to exercise his/her Privileges for such period, the MEC may require the Practitioner to take a leave of absence until he/she is able to resume the responsibilities of Medical Staff membership.

4.13-3 Resuming Exercise of Privileges. Except as set forth in this Section, upon the Practitioner's return, he/she will be allowed to assume his/her former Staff status and Privileges unless the Practitioner's term of appointment shall have expired, in which case he/she shall make application for reappointment in accordance with the Medical Staff Bylaws and Rules and Regulations or applicable credentialing policies.

4.13-4 Specific Conditions. Depending on the length or reasons for a leave of absence, the MEC may, as a condition of permitting a Practitioner to resume practice and exercise Clinical Privileges, request or require the Practitioner to (a) accept proctoring from another Practitioner, (b) provide a report, establishing that the Practitioner is physically and mentally able to resume practice and exercise Clinical Privileges, or (c) provide other relevant information pertaining to his/her Clinical Privileges, such as about professional instruction or experience received

during a leave of absence. In appropriate circumstances, and subject to a Practitioner's procedural rights under these Bylaws, the MEC may recommend to the Board that a Practitioner be reinstated to a different Staff category or be granted different Clinical Privileges.

4.13-5 Denial of Request. Notwithstanding the forgoing, the MEC may deny a request for a leave of absence in consideration of the length or reasons for the requested leave and/or the patient care needs of the Hospital.

ARTICLE V. RECOGNIZED MEDICAL AFFILIATES

5.1 GENERAL REQUIREMENTS

5.1-1 Recognized Medical Affiliates are individuals, other than Practitioners, who provide medical treatment or other patient care services in the Hospital. No individual may have Patient Contact in the Hospital unless (a) he/she is an employee of or is providing services through a contract with the Hospital or (b) he/she has received appropriate Clinical Privileges or has been granted a scope of practice to perform specific services or procedures in accordance with these Bylaws. Recognized Medical Affiliates will not be members of the Medical Staff, have the right to vote or hold office in the Medical Staff organization, or have other Prerogatives of Medical Staff members, except as specifically indicated in this Article V.

5.1-2 Except as otherwise specifically provided, individuals wishing to receive Privileges or to be granted a scope of practice to perform specific procedures or services as Recognized Medical Affiliates must meet applicable basic qualifications as set forth in Section 3.2-1, must comply with applicable responsibilities as set forth in Section 3.2-2, and must meet other applicable requirements as set forth in this Article or in credentialing policies.

5.1-3 An application for Clinical Privileges or for a scope of practice to perform services or procedures as a Recognized Medical Affiliate shall be submitted and processed in the same manner as applies to Practitioners, except as otherwise set forth in this Article. It is understood that receiving Privileges or a scope of practice is not an absolute right of any individual and is subject a determination of the need for the services in consideration of the Hospital's employment or independent contracts for the same services.

5.1-4 The terms of Recognized Medical Affiliates who are credentialed in accordance with Section 5.2 shall be consistent with the appointment periods of Practitioners. The usual terms of Medical Affiliates who have been granted a scope of practice to perform procedures and services in accordance with Section 5.3 shall be two (2) years.

5.1-5 Review of the performance of Recognized Medical Affiliates and determining procedures for collegial intervention and corrective action for these individuals shall be as set forth in Sections 5.4 and 5.5 of these Bylaws.

5.2 REQUIREMENTS FOR RECOGNIZED MEDICAL AFFILIATES

Individuals wishing to perform procedures and services as Physician Assistants, Psychologists, Anesthesiologist Assistants, Certified Registered Nurse Anesthetists, Advanced Practice Nurses, Audiologists, or Speech Pathologists must meet applicable requirements as set forth in this Section. These categories of health care professionals shall be eligible to submit applications and to be considered for Clinical Privileges in accordance with the requirements that apply to each category. Applications submitted in accordance with this Section 5.2 shall be reviewed by the Recognized Medical Affiliates Committee, which will make a recommendation to the MEC. The MEC will review the recommendation and make a recommendation to the Board as to whether Clinical Privileges should be granted, what the Privileges should be, and whether any conditions should be placed on the exercise of these Privileges. After considering the recommendation of the MEC, the Board will decide the matter. The Board will submit Special Notice to the applicant, indicating whether he/she has been granted Privileges, the specific Privileges the applicant may exercise in the Hospital, and any conditions that apply to the exercise of these Privileges.

5.2-1 Physician Assistants.

A. Qualifications. In addition to meeting the requirements set forth in Section 3.2-1 of these Bylaws, including evidence of malpractice insurance, an applicant for Privileges as a Physician Assistant must provide evidence that he/she:

(i) is a graduate of a physician assistant program accredited by the Committee on Allied Health, Education and Accreditation of the American Medical Association;

(ii) has passed the national commission on certification of physician assistants examination and has been certified by the National Commission on Certification of Physician Assistants or its successor;

(iii) holds a current license as a Physician Assistant issued in accordance with Missouri law (334 RSMo); and

(iv) is an employee of or under contract with the Hospital or an individual Practitioner or group of Practitioners, some of whom are members of the Medical Staff with Privileges that are consistent with the Privileges the applicant seeks, who will supervise the applicant as set forth in Section 5.2-1B.

B. Supervising Practitioner. In addition to the information set forth above, an applicant for Privileges as a Physician Assistant must provide:

(i) a written agreement between the applicant and the supervising Practitioner that defines the delegation of health care services to the applicant consistent with the authority granted to the Physician Assistant under state law and the review of these services by the supervising Practitioner;

(ii) verification that the health care services to be performed by the Physician Assistant are consistent with the Practitioner's Clinical Privileges at the Hospital;

(iii) written documentation that the supervising Practitioner will accept responsibility and accountability for the medical care the Physician Assistant will provide; and

(iv) verification that the applicant will notify the Hospital if the arrangement with the supervising Practitioner is revised, expires or terminates, or if the supervising Practitioner's Clinical Privileges are lost or modified, in which case the Physician Assistant's Clinical Privileges will similarly lapse or be modified.

C. Provision of Services. The Privileges of Physician Assistants will not exceed the scope of practice authorized by state law and the Clinical Privileges of the supervising Practitioner. The services of Physician Assistants will be provided in accordance with the following requirements:

(i) The scope of practice of a Physician Assistant must be made known to the appropriate department chiefs, division chairs, and department directors and managers by the Physician Assistant;

(ii) Physician Assistants will provide services under the oversight and direction of the responsible supervising Practitioner, and will not have the authority to admit patients;

(iii) All patient care activities of Physician Assistants shall be recorded in the patient's medical record by the Physician Assistant;

(iv) Physician Assistants may initiate, write and transmit orders upon the direct request and instruction of the supervising Practitioner;

(v) Physician Assistants may examine and treat patients but they shall not undertake any intrusive or invasive procedure except in

accordance with state law and in the presence of and under the direct supervision of the responsible supervising Practitioner;

(vi) Physician Assistants shall not prescribe or dispense any drugs independent of the supervising Practitioner except as authorized by state law and as permitted by the Hospital; and

(vii) Physician Assistants shall not practice or attempt to practice at any location where the supervising Practitioner is not promptly available for consultation, assistance and intervention.

5.2-2 Psychologists.

A. Qualifications. In addition to meeting the requirements set forth in Section 3.2-1 of these Bylaws, including evidence of malpractice insurance, an applicant for Privileges as a Psychologist must provide evidence that he/she:

(i) has a doctorate in psychology or other appropriate training necessary for a Missouri licensure, as defined in state law (337.025 RSMo);

(ii) holds a current license as a Psychologist issued in accordance with Missouri law; and

(iii) is certified as a health service provider as defined by state law (337.033 RSMo).

B. Provision of Services. The Privileges of Psychologists will not exceed the scope of practice authorized by state law. The services of individuals with these Privileges will be provided in accordance with the following requirements:

(i) The scope of practice of a Psychologist must be made known to the Chief of the Department of Medicine and the director and manager of behavioral health by the Psychologist;

(ii) Psychologists may not admit patients to the Hospital, but may provide patient care services in consultation with an attending Practitioner;

(iii) Psychologists shall make appropriate entries in the medical record pertaining to all patient care services, treatment, findings, opinions, testing and results; and

(iv) The exercise of Privileges shall be under the jurisdiction of the Chief of Medicine.

If a Psychologist has not had any Patient Contact or provided any consulting services pertaining to the medical needs of patients for two (2) consecutive two (2) year terms as a Recognized Medical Affiliate, as determined by the MEC, then that individual's Privileges shall lapse. The individual may reapply for Privileges as a Recognized Medical Affiliate after at least one (1) year and his/her application will be reviewed and processed in accordance with those of other new applicants.

5.2-3 Anesthesiologist Assistant.

A. Qualifications. In addition to meeting the requirements set forth in Section 3.2-1 of these Bylaws, including evidence of malpractice insurance, an applicant for Privileges as an Anesthesiologist Assistant must provide evidence that he/she:

(i) has completed a training program as an Anesthesiologist Assistant that is accredited by the Committee on Accreditation of Allied Health Education Programs;

(ii) holds a current license or registration as an Anesthesiologist Assistant issued in accordance with Missouri law (334.400 through 334.430 RSMo);

(iii) has passed the certifying examination administered by the National Commission for Certification of Anesthesiologist Assistants; and

(iv) is an employee of or under contract with the Hospital or an individual Practitioner or group of Practitioners who are members of the Medical Staff with Clinical Privileges in anesthesiology, who will supervise the applicant as set forth in Section 5.2-3B.

B. Supervising Practitioner. In addition to the information set forth above, an applicant for Privileges as an Anesthesiologist Assistant must provide:

(i) a written agreement between the applicant and a Practitioner with Clinical Privileges in anesthesiology, who will serve as the supervising Practitioner, that defines the delegation of health care services to the applicant and the review of these services by the supervising Practitioner;

(ii) verification that the health care services to be performed by the Anesthesiologist Assistant are consistent with the Practitioner's Clinical Privileges at the Hospital;

(iii) written documentation that the supervising Practitioner will accept responsibility and accountability for the medical care that the Anesthesiologist Assistant and will be present in the facility and immediately available to provide assistance when the Anesthesiologist Assistant is providing services; and

(iv) verification that applicant will notify the Hospital if the arrangement with the supervising Practitioner is revised, expires or terminates, or if the supervising Practitioner's Clinical Privileges are lost or modified, in which case the Anesthesiologist Assistant's Clinical Privileges will similarly lapse or be modified.

C. Provision of Services. The Privileges of Anesthesiologist Assistants will not exceed the scope of practice authorized by state law or the Clinical Privileges of the supervising Practitioner. The services of Anesthesiologist Assistants will be provided in accordance with the following requirements:

(i) The scope of practice of an Anesthesiologist Assistant must be made known to the Chief of the Department of Anesthesiology, the Chief of the Department of Surgery, and the Director of the Department of Surgery by the Anesthesiologist Assistant;

(ii) Anesthesiologist Assistants will provide services under the direction and supervision of the responsible supervising Practitioner, and they will not have the authority to admit patients;

(iii) Anesthesiologist Assistants may perform procedures relating to anesthesia services as authorized by state law (334.402 RSMo), and as set forth herein and permitted by the Hospital;

(iv) Anesthesiologist Assistants may pretest and calibrate anesthesia delivery systems, assist with the implementation of monitoring techniques, establish airway interventions, administer blood products and fluids, and administer infusions in accordance with the orders of the supervising Practitioner;

(v) Anesthesiologist Assistants may administer drugs as authorized by the supervising Practitioner but may not prescribe controlled substances or other drugs; and

(vi) Anesthesiologist Assistants shall not practice or attempt to practice at any location unless the supervising Practitioner is immediately available for consultation, assistance and intervention.

5.2-4 Certified Registered Nurse Anesthetists.

A. Qualifications. In addition to meeting the requirements set forth in Section 3.2-1 of these Bylaws, including evidence of malpractice insurance, an applicant for Privileges as a Certified Registered Nurse Anesthetist must provide:

(i) evidence that he/she is a registered professional nurse as defined in state law (335.016(2) RSMo) who has had education beyond the basic nursing education;

(ii) evidence that he/she has satisfactorily completed a nurse anesthesia program approved by the Council on Accreditation of Education Programs of Nurse Anesthesia, and holds a current certification from the Council on Certification or Council on Recertification of Nurse Anesthetists or has completed the certification process and is awaiting the results of examination required for certification and meets criteria for advanced practice nurses established by state law and the Missouri State Board of Nursing; and

(iii) written documentation that he/she is an employee of or under contract with the Hospital or an individual Practitioner or group of Practitioners who are members of the Medical Staff with Clinical Privileges in anesthesiology, who will supervise the applicant as set forth in Section 5.2-4B.

B. Collaborating Practitioner. In addition to the information set forth above, an applicant for Privileges as a Certified Registered Nurse Anesthetist must provide:

(i) a written agreement between the applicant and the collaborating Practitioner that defines the delegation of health care services to the applicant consistent with the authority granted to the Certified Registered Nurse Anesthetist under state law and the review of these services by the collaborating Practitioner;

(ii) verification that the health care services to be performed by the Certified Registered Nurse Anesthetist are consistent with the Practitioner's Clinical Privileges at the Hospital;

(iii) written documentation that the collaborating Practitioner will accept responsibility and accountability for the medical care that the Certified Registered Nurse Anesthetist will provide in the Hospital; and

(iv) verification that the applicant will notify the Hospital if the collaborative practice arrangement with the collaborating Practitioner is revised, expires or terminates, or if the collaborating Practitioner's Clinical Privileges are lost or modified, in which case the Certified Registered Nurse Anesthetist's Clinical Privileges will similarly lapse or be modified.

C. Provision of Services. The Privileges of Certified Registered Nurse Anesthetists will not exceed the scope of practice authorized by state law or the Clinical Privileges of the collaborating Practitioner. The services of Certified Registered Nurse Anesthetists will be provided in accordance with the following requirements:

(i) The scope of practice of a Certified Registered Nurse Anesthetist must be made known to the Chief of the Department of Anesthesiology, the Chief of the Department of Surgery, and the Director of the Department of Surgery by the CRNA;

(ii) Certified Registered Nurse Anesthetists will provide services under the oversight and direction of the responsible collaborating Practitioner, and they will not have the authority to admit patients;

(iii) Certified Registered Nurse Anesthetists may perform procedures relating to anesthesia services as authorized by state law and the collaborating practice agreement, which shall include the authority to pretest and calibrate anesthesia delivery systems, assist with the implementation of monitoring techniques, establish airway interventions, administer blood products and fluids, and administer infusions;

(iv) Certified Registered Nurse Anesthetists may not prescribe or administer any drugs or devices except as authorized by state law and permitted by the Hospital and they shall not have the authority to prescribe controlled substances; and

(v) Certified Registered Nurse Anesthetists shall not practice or attempt to practice at any location unless the collaborating Practitioner is promptly available for consultation, assistance and intervention.

5.2-5 Advanced Practice Nurse.

A. Qualifications. An individual seeking Privileges as an Advanced Practice Nurse must have received training as either a certified nurse midwife, a certified nurse practitioner, or a certified clinical nurse specialist. In addition to meeting the requirements set forth in Section 3.2-1 of these

Bylaws, including evidence of malpractice insurance, an applicant for Privileges as an Advanced Practice Nurse must provide:

(i) evidence that he/she has a Missouri license as a registered professional nurse as defined in state law (335.016(2) RSMo) and has had education beyond the basic nursing education;

(ii) documentation that he/she is certified by a nationally recognized certifying body as having a nursing specialty as indicated above;

(iii) evidence that he/she meets criteria for advanced practice nurses established by state law and the Missouri State Board of Nursing and holds current state certification as an advanced practice nurse; and

(iv) documentation that he/she is an employee of or under contract with the Hospital or an individual Practitioner or group of Practitioners who are members of the Medical Staff with Privileges that are consistent with the Privileges the applicant seeks, who will supervise the applicant as set forth in Section 5.2-5B.

B. Collaborating Practitioner. In addition to the information set forth above, an applicant for Privileges as an Advanced Practice Nurse must provide the following:

(i) a written agreement between the applicant and the collaborating Practitioner that defines the delegation of health care services to the applicant consistent with the authority granted to the Advanced Practice Nurse under state law and the review of these services by the collaborating Practitioner;

(ii) verification that the health care services to be delegated are consistent with the Practitioner's Clinical Privileges at the Hospital;

(iii) the express agreement of the collaborating Practitioner that he/she will accept responsibility and accountability for the medical care that the Advanced Practice Nurse provides in the Hospital; and

(iv) verification that the applicant will notify the Hospital if the collaborative practice arrangement with the collaborating Practitioner is revised, expires or terminates, or if the collaborating Practitioner's Clinical Privileges are lost or modified, in which case the Advanced Practice Nurse's Privileges will similarly lapse or be modified.

C. Provision of Services. The Privileges of an Advanced Practice Nurse will not exceed the scope of practice authorized by state law or the Clinical Privileges of the collaborating Practitioner. The services of an Advanced Practice Nurse will be provided in accordance with the following requirements:

(i) The scope of practice of an Advanced Practice Nurse must be made known to the appropriate department chiefs, division chairs, and department directors and managers by the APN;

(ii) Advanced Practice Nurses will provide services under the oversight and control of the responsible collaborating Practitioner, and they will not have the authority to admit patients;

(iii) Advanced Practice Nurses may perform such procedures as are authorized by state law and the collaborating practice agreement and as permitted by the Hospital, which may include examining and treating patients and initiating, writing and transmitting orders upon the direct request and instruction of the supervising Practitioner;

(iv) Advanced Practice Nurses may prescribe and administer drugs as authorized by state law and the collaborating practice agreement and as permitted by the Hospital;

(v) Advanced Practice Nurses will not practice or attempt to practice at any location unless the collaborating Practitioner is available for consultation, assistance and intervention;

(vi) All patient care activities of Advanced Practice Nurses shall be recorded in the patient's medical record by the Advanced Practice Nurse; and

(vii) Advanced Practice Nurses shall not initiate any patient care activities which are not expressly defined in the collaborative practice agreement and permitted by the Hospital.

5.2-6 Audiologists and Speech Pathologists.

A. Qualifications. In addition to meeting the requirements set forth in Section 3.2-1 of these Bylaws, including evidence of malpractice insurance, an applicant for Privileges as an Audiologist or Speech Pathologist must provide evidence that he/she:

(i) has a master's or doctoral degree in the applicable specialty from an institution accredited by the Council on Academic Accreditation of the American Speech-Language-Hearing Association;

(ii) has completed a clinical fellowship in the applicable specialty; and

(iii) has passed an examination or has met alternate requirements for licensure in that specialty, and has a valid license issued in accordance with state law (345.010 through 345.080 RSMo).

B. Provision of Services. The Privileges of Audiologists and Speech Pathologists will not exceed the scope of practice authorized by state law for each specialty. The services of individuals with these Privileges will be provided in accordance with the following requirements:

(i) The scope of practice of an Audiologist and Speech Pathologist must be made known to appropriate department chiefs, division chairs, and department directors and managers by the Audiologist or Speech Pathologist;

(ii) Audiologists and Speech Pathologists may not admit patients to the Hospital, but they may provide patient care services at the request of attending Practitioners; and

(iii) Audiologists and Speech Pathologists shall make appropriate entries in the medical records reflecting their patient care services, treatment, findings, opinions, testing and results.

If an Audiologist or Speech Pathologist has not had any Patient Contact or provided any consulting services pertaining to the medical needs of patients for two (2) consecutive two (2) year terms as a Recognized Medical Affiliate, as determined by the MEC, then that individual's Privileges shall lapse. The individual may later reapply for Privileges as a Recognized Medical Affiliate and his/her application will be reviewed and processed in accordance with those of other new applicants.

5.3 REQUIREMENTS FOR OTHER MEDICAL AFFILIATES

Individuals who wish to perform or assist in performing any medical procedures or to have any Patient Contact in the Hospital who are not members of the Medical Staff or Recognized Medical Affiliates who have received Privileges in accordance with Section 5.2 must either (a) be employees of or under contract with the Hospital or (b) be granted a scope of practice to perform the specific procedures or services in accordance with the requirements that are set forth in this Section.

A. Application Process. Before providing any medical services or having any Patient Contact in the Hospital, an individual must submit an application to be granted a scope of practice as a Medical Affiliate that includes the following information:

(i) a description of the services and procedures the applicant wishes to perform or assist in performing;

(ii) the applicant's licensure, certification, or other training and experience to perform the specified services and procedures;

(iii) documentation that the applicant either has a contract with the Hospital to perform the requested procedures and services or is an employee of or under contract with an individual Practitioner or group of Practitioners who are members of the Medical Staff with Privileges that are consistent with the services and procedures the applicant wishes to perform;

(iv) written documentation that sets forth the oversight that will be provided by the supervising Practitioner and the express agreement of the Practitioner to accept responsibility and accountability for the medical services that the applicant will provide in the Hospital, as applies;

(v) written assurance that if the supervising Practitioner's Clinical Privileges are lost or modified, the applicant's scope of approval will similarly lapse or be modified, as applies;

(vi) evidence of insurance coverage;

(vii) references regarding the applicant's professional competence and behavior; and

(viii) such additional information as is requested.

B. Categories and Qualifications. The categories of Medical Affiliates and the qualifications and other requirements that apply to each category will be established by the President, upon the recommendations of the Recognized Medical Affiliates Committee and the MEC and subject to the approval of the Board, as set forth in Section 5.4B. The qualifications of individuals who may be granted a scope of practice to perform specific services or procedures consistent with each Medical Affiliates category will include the following:

(i) the specific training, experience, and/or other qualifications that a Medical Affiliate must have;

(ii) the scope of practice, and specifically the procedures and services that a Medical Affiliate may perform; and

(iii) any limitations or conditions that apply, including the supervision requirements.

C. Procedures. The Recognized Medical Affiliates Committee will review the qualifications of each applicant who seeks to perform services or procedures as a Medical Affiliate and will determine whether the applicant meets the requirements established for that Medical Affiliates category. The Recognized Medical Affiliates Committee will make a recommendation to the President, who will review the recommendation and decide the matter as set forth in these Medical Staff Bylaws and Rules and Regulations. The President will submit Special Notice to the applicant, indicating whether he/she has been granted a scope of practice to perform services or procedures as a Medical Affiliate, the specific services and procedures that he/she may perform, and any conditions that apply.

D. Responsibilities. Each Medical Affiliate shall:

(i) meet the basic responsibilities required by Section 3.4 as they apply;

(ii) assume appropriate responsibility within his/her defined scope of practice for the care of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care, consistent with the scope of practice of another Medical Affiliate and the concurrence of supervising Practitioners, as applies; and

(iii) participate in those aspects of patient care monitoring and other quality assurance activities appropriate to his/her license or certificate, if any, and his/her scope of practice as a Medical Affiliate, and discharge such other functions as may from time to time be required.

E. Existing Medical Affiliates. An individual who is performing procedures or services consistent with those of a Medical Affiliate who has not received approval from the Hospital that delineates an allowable scope of practice of the individual, must submit an application and such other information as is required in accordance with Section 5.3A within sixty (60) days of the effective date of this Section. Subject to the submission and review of this information, any such individual will be permitted to continue to perform the services and procedures he/she has been

performing within the Hospital if the individual has been performing in a satisfactory manner as determined by the MEC and the Recognized Medical Affiliates Committee and if the scope of practice and Practitioner oversight of the individual's services are consistent with the requirements of state law.

5.4 RECOGNIZED MEDICAL AFFILIATES COMMITTEE

A Recognized Medical Affiliates Committee will be created and maintained to review the qualifications and performance of individuals who apply for and receive Clinical Privileges as Recognized Medical Affiliates as set forth in Section 5.2 and who apply for and are granted a scope of practice as Medical Affiliates as set forth in Section 5.3. The composition and responsibilities of the Recognized Medical Affiliates Committee shall be as follows.

A. Composition. The Recognized Medical Affiliates Committee will consist of Practitioners, Recognized Medical Affiliates, and Hospital staff who are appointed by the President, with the concurrence of the Chief of Staff. Members of the Recognized Medical Affiliates Committee will be expected to serve two (2) year terms, but they may serve for shorter or longer periods as mutually agreed by the member and the President. Best efforts will be made to stagger the terms. The Committee will be comprised of at least the following members, and may include additional members as agreed by the Chief of Staff and President:

(i) two representatives of the Medical Staff, including one member of the Credentials Committee, and one member with Privileges in anesthesiology, psychiatry, internal medicine, surgery, or obstetrics and gynecology;

(ii) one Recognized Medical Affiliate with Clinical Privileges in either psychology, audiology, or speech pathology;

(iii) one Recognized Medical Affiliate with Clinical Privileges as a Certified Registered Nurse Anesthetist or Anesthesiologist Assistant;

(iv) one Recognized Medical Affiliate with Clinical Privileges as an Advanced Practice Nurse;

(v) two Medical Affiliates who have been granted a scope of practice to provide services in accordance with Section 5.3; and

(vi) one representative of the Hospital appointed by the President, who will chair the Committee.

B. Responsibilities. The Recognized Medical Affiliates Committee will meet at least four (4) times a year, or more frequently as decided by the chair. The Committee will have the following authority and responsibilities and will observe the following procedures:

(i) The Committee will periodically review the requirements that apply to each category of Recognized Medical Affiliates and recommend modifications, as appropriate, in accordance with the procedures set forth in this Section.

(ii) The Committee may propose modifications of the requirements for Recognized Medical Affiliates as set forth in Section 5.2 and submit them to the MEC, which will review the recommendations and may accept them or make further modifications. The MEC will submit its recommendations to the Medical Staff and Board for approval as set forth in Section 16.2 of these Bylaws.

(iii) The Committee will propose requirements for Medical Affiliates as set forth in Section 5.3 and will submit them to the MEC, which will review them and submit their recommendations to the President. The President will review the recommendations and may refer them back to the Recognized Medical Affiliates Committee and MEC for further consideration. These requirements are subject to the final approval of the Board, as set forth in Section 5.3B of these Bylaws.

(iv) The Recognized Medical Affiliates Committee will review the applications of individuals seeking Clinical Privileges as Recognized Medical Affiliates as set forth in Section 5.2 and will submit its report and recommendations to the MEC. The MEC will review the Committee's recommendations and may accept them or reject them in whole or part. The MEC will submit its recommendations, along with the report and recommendations of the Committee, to the Board for a decision.

(v) The Committee will review the applications of individuals seeking to be granted a scope of practice as a Medical Affiliate as set forth in Section 5.3 and will submit its recommendations to the President for a decision. The President may accept the recommendation, may refer the matter back to the Committee for further consideration, or may reject the recommendation in whole or part.

(vi) Upon its own initiative or upon a request from the MEC or the President, the Committee will review the performance of a Recognized Medical Affiliate in accordance with the procedures

that are set forth in Section 5.5 of these Bylaws. The Committee may refer specific individuals, cases or situations to the MEC for further review by the CQI Committee or another committee, department or division of the Medical Staff.

(vii) The Committee will develop and modify, from time to time, policies and procedures to implement the responsibilities set forth in this Section. Such policies and procedures are subject to the review and concurrence of the President and MEC, and must not be inconsistent with these Bylaws.

5.5 PROCEDURAL RIGHTS AND RESPONSIBILITIES

A. Recognized Medical Affiliates with Privileges. Individuals who have applied for or received Clinical Privileges in accordance with Section 5.2 will have the rights and responsibilities of Practitioners as described in Articles VI through IX and the Fair Hearing Plan of the Bylaws, except as set forth below.

(i) To the extent that the Bylaws give authority to the Credentials Committee or other committees, departments or divisions of the Medical Staff to review and make recommendations about the qualifications, professional performance, behavior and Privileges of Recognized Medical Affiliates, these duties shall be performed by the Recognized Medical Affiliates Committee.

(ii) If there is concern about the professional performance or behavior of a Recognized Medical Affiliate at any time, the matter will be referred to the Recognized Medical Affiliates Committee, which will review the matter and make a recommendation to the MEC. The MEC will follow the procedures that apply to Practitioners, except as provided in this Article V.

(iii) If a hearing concerning a Recognized Medical Affiliate is held pursuant to Part B of the Fair Hearing Plan, then the Hearing Committee that is appointed in accordance with Section B-2 will include at least one (1) Recognized Medical Affiliate who has received Clinical Privileges pursuant to Section 5.2 of these Bylaws. A Practitioner will chair the Hearing Committee.

B. Other Medical Affiliates. Notwithstanding any other provisions of these Bylaws, individuals who have been granted a scope of practice to perform services or procedures as Medical Affiliates in accordance with Section 5.3 shall have the following rights and responsibilities.

(i) The qualifications and performance of these Medical Affiliates will be reviewed by the Recognized Medical Affiliates Committee. If there is concern about the professional performance or behavior of a Medical Affiliate at any time, the Recognized Medical Affiliates Committee will make a recommendation and submit supporting information to the President.

(ii) The President will review the recommendation and accompanying information that is submitted by the Committee. Upon considering a recommendation of the Recognized Medical Affiliates Committee, if the President believes that a Medical Affiliate's scope of practice to perform specific services or procedures in the Hospital should be modified or revoked, the President will send Special Notice to the Medical Affiliate and to the Practitioner under whose supervision the individual performs these services or procedures, if applicable. The Medical Affiliate may request a review of the matter.

(iii) If the Medical Affiliate requests a review hearing, then the President will designate a review committee consisting of three to five individuals, including at least one individual with Clinical Privileges in accordance with Section 5.2, at least one individual who has been granted a scope of practice to provide services in accordance with Section 5.3, and at least one representative of the Hospital. At the discretion of the President, up to two other individuals may be appointed to serve on the review committee. The committee will conduct an informal review of the matter and will provide notice to the Medical Affiliate of the date, time, location and procedures that will apply to the review hearing. The procedures will include giving the Medical Affiliate the right to make a statement and present written evidence. After considering the matter, the committee will make a recommendation to the President, who will make a recommendation to the Board as to whether to revoke or modify the individual's approval to perform services and procedures as a Medical Affiliate.

ARTICLE VI. PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL PROCEDURE

The Medical Staff through its designated departments, divisions, committees, and officers shall consider and evaluate each application for appointment or reappointment to the Medical Staff and Clinical Privileges to practice at the Hospital, and each request for modification of Staff membership status or Privileges. Except as otherwise provided in these Bylaws or credentialing policies, these functions also shall be performed in connection with the application of any individual who seeks to be a Recognized Medical

Affiliate and to exercise Clinical Privileges or any individual who wishes to provide specified services as a Medical Affiliate in the Hospital.

6.2 APPLICATION FOR INITIAL APPOINTMENT

6.2-1 Application Form. Each initial application for appointment to the Medical Staff shall be in writing, signed by the Practitioner and submitted on the form prescribed by the Hospital in consultation with the Medical Executive Committee.

6.2-2 Content. The application form shall include:

A. Acknowledgment and Agreement. A statement that the Practitioner has received the Bylaws, Rules, and Regulations of the Medical Staff and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or Clinical Privileges, and to be bound by the terms thereof in all matters relating to the review and consideration of his/her application without regard to whether or not he/she is granted Staff membership and Clinical Privileges.

B. Qualifications. Detailed information concerning the Practitioner's qualifications, including but not limited to information in satisfaction of the basic qualifications specified in Section 3.2-1 and any additional qualifications specified in these Bylaws for the particular Medical Staff category to which the Practitioner requests appointment. This shall include documentation of continuing education that applies to the application.

C. Requests. A specific statement of the Medical Staff category, department, division, and Clinical Privileges for which the Practitioner wishes to be considered.

D. References. The names of at least two (2) persons who have worked with the Practitioner and have personally observed his/her professional performance who can provide accurate references as to his/her clinical ability, ethical character, and ability to work with others.

E. Sanctions. Information as to whether the Practitioner's membership status and/or Clinical Privileges have ever been revoked, suspended, reduced or not renewed at any other hospital or health care institution, as to whether the Practitioner has ever pleaded guilty to or been convicted of a crime, other than minor traffic violations, and as to whether any of the following have ever been suspended, revoked, denied, or voluntarily or involuntarily surrendered:

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

(ii) specialty board certification;

(iii) license to practice medicine or any other profession in any jurisdiction; or

(iv) Drug Enforcement Agency (DEA) or Bureau of Narcotics and Dangerous Drugs (BNDD) number.

If any such actions were ever taken, the Practitioner must provide specific information that explains the action that was taken and the reasons for the action. The records identified above shall be maintained on a current basis with the Medical Staff Services Office.

F. Professional Liability Insurance. A statement and current evidence that the Practitioner carries professional liability insurance and all information with respect thereto required by Section 15.2 of these Bylaws, and information on all pending malpractice claims, settled claims, and judgments asserted including a consent to the release of information by his/her present and prior malpractice insurance carrier(s) or the carrier for the group by which the Practitioner is employed or is under contract.

G. Notification of Release and Immunity Provisions. Statements notifying the Practitioner of the scope and extent of the authorization, confidentiality, immunity and release provisions of these Bylaws.

H. Administrative Remedies. A statement whereby the Practitioner agrees that, if an adverse action is recommended or taken as defined in Part A1 of the Fair Hearing Plan with respect to the status of his/her Medical Staff membership and/or Clinical Privileges, he/she will exhaust the internal remedies afforded by these Bylaws and Rules and Regulations as a condition precedent to taking any formal legal action.

6.3 EFFECT OF APPLICATION

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

A. signifies his/her willingness to appear for interviews in regard to his/her application for appointment or reappointment;

B. authorizes Hospital and/or Medical Staff representatives to consult with others who have been associated with the Practitioner and/or who have information bearing on his/her experience, competence, ability and judgment;

C. consents to the inspection by Hospital and/or Medical Staff representatives of all records and documents that may be material to an evaluation of

his/her professional qualifications and ability to carry out the Clinical Privileges he/she requests as well as of his/her professional ethical qualifications for Medical Staff membership;

D. releases from any liability all Hospital and/or Medical Staff representatives for all acts performed in connection with evaluating the Practitioner and his/her credentials;

E. releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital and/or Medical Staff representatives concerning the Practitioner's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment and Clinical Privileges; and

F. authorizes and consents to Hospital and/or Medical Staff representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with performance of providers of medical services and the quality and efficiency of patient care, with information that is or may be relevant to such matters concerning the Practitioner, and releases Hospital and/or Medical Staff representatives from liability for so doing provided that such furnishing of information is done in good faith and without malice.

6.4 PROCESSING THE APPLICATION

6.4-1 Applicant's Burden. The Practitioner shall have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, and demonstrated ability to perform the Clinical Privileges requested, and of resolving any doubts about these or any other qualifications. This burden shall include the disclosure of information or reports regarding treatment or counseling with respect to substance abuse at any time following initial licensure, and may include submission to a medical or psychiatric examination, at the Practitioner's expense, if it is deemed necessary or appropriate by the Medical Executive Committee, which may select the examining physician.

6.4-2 Verification of Information. The Practitioner shall be responsible for completing the forms and obtaining the information that is necessary to complete his/her application, and for submitting this information to the President, who shall, in timely fashion through a designee, seek to collect and verify the references, licensure, and other information submitted by or on behalf of the Practitioner. Verification shall include queries of the National Practitioner Data Bank, the state licensing authority, and other pertinent sources as set forth in Section 6.4-5 C of these Bylaws. For applicants seeking Clinical Privileges only to provide interpretive services through telemedicine, the Hospital may request that the Practitioner provide a credentialing packet from another Medicare-certified

hospital as the basis for making the privileging decision. The President or designee shall promptly notify the Practitioner if the Hospital experiences any problems in its collection or verification efforts. If a Practitioner fails to submit all of the information that is necessary to complete the application within sixty (60) days of receiving written notice from the Hospital, then the Practitioner will be deemed to have withdrawn his/her application for Medical Staff membership and Privileges. When collection and verification of the required information has been accomplished, then the application will be considered complete, and the President will transmit the application and supporting materials to the chief of the applicable department(s) of the Medical Staff and the chairman of the Credentials Committee. Within thirty (30) days of receipt of the information, the department will review the application and supporting information and submit its recommendation to the Credentials Committee.

6.4-3 Credentials Committee File and Action.

A. The Credentials Committee shall review the application, the supporting documentation, the recommendation of the department and other professional peers, and such other information as is available and as may be relevant to its consideration of the Practitioner's qualifications for appointment to the Medical Staff in the specific Staff category, and with the department or division affiliation and Clinical Privileges that have been requested.

B. The Credentials Committee shall create and maintain one file (the Credentials File) which shall serve as the written appointment record to be maintained on each Practitioner. All written information that relates to the credentials or Clinical Privileges of a Practitioner shall be submitted for inclusion in the Credentials File as provided in Section 7.8. The Credentials File shall be accessible to authorized representatives of the Medical Staff and President and to the Practitioner, subject to the requirements of these Bylaws. Information that is not related to the credentials or Clinical Privileges of Practitioners shall not be maintained.

C. Upon completion of its review, the Credentials Committee shall transmit a written report to the Medical Executive Committee on the prescribed form with recommendations as to Medical Staff appointment and, if appointment is recommended, as to the Medical Staff category, department and division affiliations, Clinical Privileges and any special conditions that should apply to the appointment. The Credentials Committee may recommend that the Medical Executive Committee defer action on the application to obtain additional information or for other reasons. The reason for such recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the Committee, which shall be transmitted with the report.

6.4-4 Medical Executive Committee Action. At its next regular meeting after receipt of the report and recommendations of the Credentials Committee concerning each Practitioner who seeks appointment to the Medical Staff, the Medical Executive Committee shall consider the information provided by the Credentials Committee and will either make a recommendation to the Board or will defer the matter until its next meeting. Unless the matter is deferred, the Medical Executive Committee will forward its recommendation to the President for transmittal to the Board. The MEC will provide the Board a written report on the prescribed form, indicating, as to each Practitioner, whether Medical Staff appointment is recommended and, if appointment is recommended, the Medical Staff category and Clinical Privileges that should be granted, and any special conditions that should apply to the appointment. The reasons for each recommendation shall be stated in the report and shall be supported by reference to the completed application and other documentation available to the Medical Executive Committee, all of which shall be transmitted with the report. After consideration by the Board, the completed application, report, and all other documentation considered by the Medical Executive Committee shall be retained in accordance with Section 7.8.

6.4-5 Effect of Medical Executive Committee Action.

A. Deferral. Action by the Medical Executive Committee to defer an application for further consideration must be followed up at the next regularly scheduled meeting of the MEC with a recommendation.

B. Favorable Recommendation. When the recommendation of the MEC is favorable to the Practitioner, the President shall promptly forward it to the Board together with all supporting documentation. The recommendation may be referred to a committee that has been authorized to act on behalf of the Board if the application and supporting information meets the requirements set forth in Section 6.4-5C of these Bylaws.

C. Review of Favorable Recommendation by Board Committee. An authorized committee of the Board may act on behalf of the Board if an application includes evidence of each of the following or meets each of these conditions, as evidenced by queries of the National Practitioner Data Bank, the state licensing authority, and other pertinent sources:

(i) The Practitioner has a license to practice medicine in Missouri;

(ii) The Practitioner has current, unrestricted federal and state controlled substance licensure or certification;

(iii) No action has been taken against the Practitioner's license to practice medicine in any state or against the Practitioner's privileges to practice at any hospital;

(iv) The Practitioner has had no malpractice claims activity, including adverse claims, settlements or judgments;

(v) Required references have been provided and these references do not raise concerns about the Practitioner's qualifications; and

(vi) No concerns have been raised about the Practitioner by any member of the Medical Staff who is knowledgeable about the Practitioner's professional qualifications.

D. Adverse Recommendation. When the recommendation of the Medical Executive Committee is adverse to the Practitioner, the President shall immediately so inform the Practitioner by Special Notice, and he/she shall be entitled to the procedural rights that are set forth in ARTICLE IX and the Fair Hearing Plan. For the purposes of this Section, an "adverse recommendation" by the Medical Executive Committee is defined in Parts A-1 and A-2(a) of the Fair Hearing Plan appended hereto.

6.4-6 Board Action.

A. On Favorable MEC Recommendation. The Board may adopt a favorable recommendation of the MEC or may reject a favorable recommendation, in whole or in part. The Board also may refer a recommendation back to the Medical Executive Committee for further consideration. If the Board refers the application of a Practitioner back to the MEC for further consideration, then the Board shall state the reasons for such referral and shall set a time limit within which a subsequent recommendation shall be made by the MEC and forwarded to the Board for consideration. If the Board's action is adverse to the applicant as defined in Parts A-1 and A-2(b) of the Fair Hearing Plan, then the President shall promptly so inform the Practitioner by Special Notice, and he/she shall be entitled to the procedural rights that are set forth in ARTICLE IX and the Fair Hearing Plan.

B. After Procedural Rights. In the case of an adverse Medical Executive Committee recommendation or an adverse Board decision, the Board shall take final action in the matter only after the Practitioner has exhausted or has waived his/her procedural rights as provided in ARTICLE IX and in the Fair Hearing Plan. Action thus taken shall be conclusive, except that the Board may defer final determination by referring the matter back to the Medical Executive Committee for reconsideration. Any such referral 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 shall 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 Practitioner to the Medical Staff or to reject him/her for Staff membership.

6.4-7 Conflict Resolution. Whenever the Board's proposed decision will be contrary to the Medical Executive Committee's recommendation, the Board shall submit the matter to a joint conference of equal numbers of the Medical Staff and Board members for review and recommendation as provided in part G-2 of the Fair Hearing Plan before making its final decision.

6.4-8 Notice of Final Decision.

A. Notice of the Board's final decision shall be given, in writing, through the President, to the Medical Staff Services Coordinator, the chairmen of the Medical Executive Committee and the Credentials Committee, and the Practitioner by means of Special Notice.

B. The Special Notice shall set forth the decision and, if the decision is favorable to the Practitioner, it shall include:

(i) the Medical Staff category to which the Practitioner has been appointed;

(ii) the department and/or division to which he/she has been assigned;

(iii) the Clinical Privileges he/she may exercise; and

(iv) any special conditions attached to the appointment or to the exercise of Clinical Privileges.

C. A Practitioner may not admit or provide medical care to any patients at the Hospital or have any Patient Contact until and unless he/she has received Special Notice from the President as set forth above, indicating that he/she has been appointed to the Medical Staff and setting forth the specific Privileges that he/she will be allowed to exercise.

6.4-9 Reapplication After Adverse Appointment Decision. A Practitioner who has received a final adverse decision regarding appointment shall not be eligible to reapply for appointment to the Medical Staff for a period of at least two (2) years. Any such reapplication shall be processed as an initial application, and the Practitioner shall submit such additional information as the Hospital, the Medical Staff or the Board may require to demonstrate that the basis for the earlier adverse action no longer exists.

6.4-10 Time Periods for Processing. An application for appointment to the Medical Staff shall be considered in a timely and good faith manner by all individuals and

entities required to review the application and, except for good cause, shall be processed within the time periods specified in these Bylaws. The President shall transmit a completed application to the Credentials Committee and the chief of any applicable department of the Medical Staff upon completing the information collection and verification tasks, but in any event within thirty (30) days after receiving a complete application from a Practitioner. The chairman of the Credentials Committee and the chief of an applicable department shall initiate action on an application within thirty (30) days after receiving it from the President. As soon as is reasonably possible, but in any event within sixty (60) days following receipt of a completed application, the Credentials Committee shall make its recommendation to the Medical Executive Committee. At its next regular meeting, or the subsequent meeting of the MEC if the matter is deferred, the Medical Executive Committee shall review the application and shall make its recommendation to the Board. The Board or an appropriate committee thereof shall make a decision on the application following receipt of the recommendation of the Medical Executive Committee. A committee of the Board may act on behalf of the Board, consistent with the requirements set forth in Section 6.4-5 B.

6.5 REAPPOINTMENT PROCESS

6.5-1 Information Form for Reappointment. The President shall, at least one hundred and fifty (150) days prior to the expiration date of the current appointment period of each Medical Staff member, provide the Practitioner with such forms and information as pertain to his/her reappointment. Each Medical Staff member who seeks reappointment shall, at least one hundred twenty (120) days prior to the expiration of his/her current term of appointment, submit a complete application and all required information to the President. If a Practitioner fails to return the completed form and other required information by no more than one hundred twenty (120) days prior to the expiration of the Practitioner's current appointment period, then, if the Hospital is unable to process the application and make a decision about reappointment before the end of the Practitioner's current appointment period, the Practitioner's Medical Staff membership and Clinical Privileges may lapse at the expiration of the current term, subject to review and recommendation by the Credentials Committee and a final interpretation of the situation by the MEC.

6.5-2 Content of Reappointment Information. In applying for reappointment, a Practitioner shall provide such information as is necessary and is requested to maintain current information about the Practitioner including, without limitation:

A. continuing training, education and experience that qualifies the Practitioner for the Privileges sought on reappointment;

B. evidence of the Practitioner's current ability to perform the Privileges requested and practice in the area in which Privileges are sought, including

disclosure of treatment or counseling with respect to substance abuse at any time since last appointed;

C. the results of a medical or psychiatric examination at the Practitioner's expense, which may include an examination by a physician designated by the Hospital, MEC, or Board, if requested;

D. the name and address of any other health care organization or practice setting where the Practitioner has provided clinical services during the preceding period;

E. membership, awards, or other recognitions conferred or granted by any professional health care societies, institutions, or organizations;

F. sanctions of any kind imposed by any other health care institution, professional health care organization, or licensing or regulatory authority;

G. details about current malpractice insurance coverage and limits, or such other evidence of financial responsibility in such manner as the Medical Staff or Board shall have established, as well as pending claims and suits, and all settled claims and judgments during the preceding period, including a consent to the release of information by his/her present and prior malpractice insurance carrier(s) or the carrier for the group by which the Practitioner is employed or is under contract; and

H. other specific information about the Staff member's professional ethics, qualifications and ability, including but not limited to civil and criminal proceedings to which he/she has been a party, voluntary or involuntary relinquishment of medical staff membership at another hospital, and voluntary or involuntary limitation, reduction, surrender, or loss of clinical privileges at another hospital.

6.5-3 Verification of Information. The President shall seek to collect and verify the information that is required to be provided by the Practitioner through queries of the National Practitioner Data Bank, the state licensing authority, and other pertinent sources, including information regarding the Staff member's professional activities, performance and conduct in the Hospital. When collection and verification is accomplished, the President shall transmit the form and supporting materials to the chief of each department in which the Staff member requests Privileges and to the Credentials Committee.

6.5-4 Department Action. The department shall review the information that has been provided by or on behalf of the Practitioner, including performance data that the department has acquired during the previous appointment period through chart reviews, direct observation of the Practitioner's performance, and other means as

established by the MEC. The department shall transmit its report and recommendation, usually within thirty (30) days**,** to the Credentials Committee.

6.5-5 Credentials Committee Action. The Credentials Committee shall review each application for reappointment, including the recommendation of each department in which the Staff member has requested Privileges, and shall transmit a recommendation to the Medical Executive Committee, if possible within thirty (30) days, but in any event within sixty (60) days as to whether the Staff member's appointment should be renewed, renewed with modifications, or denied. The Credentials Committee may also recommend that the Medical Executive Committee defer action until additional information can be obtained.

6.5-6 Medical Executive Committee Action. The Medical Executive Committee shall review the relevant information that has been provided to it and shall forward its recommendation to the President for transmittal to the Board. If insufficient information is available to make a recommendation, the Medical Executive Committee may defer action on the application until additional information can be obtained, usually within thirty (30) days. When more information is available, the Medical Executive Committee will reconsider the matter, which reconsideration will be expected to occur at its next regularly scheduled meeting.

6.5-7 Final Processing and Board Action. Thereafter, the procedure provided in Sections 6.4-6 through 6.4-8 shall be followed.

6.5-8 Bases for Recommendations. Each recommendation concerning the reappointment of a Staff member and the Clinical Privileges to be granted upon reappointment shall be based on such Practitioner's professional ability and judgment in the treatment of patients, professional ethics, professional conduct, discharge of Medical Staff obligations, compliance with the Medical Staff Bylaws, Rules and Regulations, cooperation with other Practitioners, patients and Hospital staff, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the Hospital.

6.5-9 Extension of Appointment. If an application for reappointment has not been fully processed by the expiration date of the Staff member's then-current term of appointment, then the Staff member shall maintain Medical Staff membership and Clinical Privileges until such times as the processing is completed, unless the delay is due to the Practitioner's failure to complete and return in a timely manner the reappointment application form and provide all other information that is requested as set forth in Section 6.5-1, in which case the Staff member's appointment and Clinical Privileges shall lapse. Any extension of an appointment pursuant to this Section does not create a vested right in the Practitioner to continued appointment through the entire next term but only until such time as is required for the Credentials Committee, MEC and Board to process and make a decision about the application in accordance with the usual procedures set forth in these Bylaws.

6.5-10 Time Periods for Processing. Transmittal of the reappointment information and the return of this information shall be carried out in accordance with Section 6.5-1. Thereafter and except for good cause, each person, department and committee required by these Bylaws to act thereon shall complete such action in timely fashion such that all reports and recommendations concerning the reappointment of a Medical Staff member shall have been transmitted to the Medical Executive Committee for its consideration and action pursuant to Section 6.5-6 and to the Board for its action pursuant to Section 6.5-7, prior to the expiration date of the Staff membership of the Practitioner being considered for reappointment.

6.6 REQUESTS FOR MODIFICATION OF APPOINTMENT

A Medical Staff member may, either in connection with reappointment or at any other time, request modification of his/her Medical Staff category, department or division assignment, or Clinical Privileges by submitting a written application to the President on the prescribed form. Such application shall be processed in substantially the same manner as provided in Section 6.5 for reappointment.

ARTICLE VII. DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every Practitioner and Recognized Medical Affiliate providing direct clinical services at the Hospital by virtue of Medical Staff membership shall be entitled to exercise only those Clinical Privileges or scope of practice that have been specifically recommended by the Medical Executive Committee and granted by the Board or President, except as otherwise provided by these Bylaws.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2-1 Requests. Each application for appointment or reappointment to the Medical Staff, or for a modification of Privileges, must contain a request for the specific Clinical Privileges desired and must be supported by documentation of training and experience evidencing support of the request.

7.2-2 Bases for Privileges Determinations. Requests for Clinical Privileges shall be evaluated on the basis of the Practitioner's education, training, experience, and demonstrated ability and judgment. Privileges determinations in connection with periodic reappointment or otherwise shall include consideration of observed clinical performance and the documented results of the patient care evaluation and other quality accountability activities required by the Hospital or Medical Staff Bylaws and Rules and Regulations. Privileges determinations also may be based on pertinent information concerning clinical performance obtained from other sources, especially including other institutions and health care settings where a

Practitioner exercises or has exercised Clinical Privileges. Such information shall be added to and maintained in the Medical Staff Credentials File.

7.2-3 Procedure. Except as otherwise provided in these Bylaws or applicable credentialing policies, requests for Clinical Privileges shall be processed pursuant to the procedures outlined in ARTICLE VI.

7.2-4 Privileges in New Areas and Outside of a Specialty. Requests for Privileges in new areas or in areas that traditionally are exercised by Practitioners from a specialty other than the Practitioner's primary specialty will not be processed until the steps outlined in this Section have been completed and a recommendation has been made regarding the Practitioner's eligibility to request and exercise the Privileges in question. When a Practitioner seeks Privileges in a new area or in an area that is outside of his/her usual specialty, the following procedures shall be followed:

A. The Credentials Committee will review the request and such standards and requirements as apply to granting the Privileges.

B. If no specific requirements have been adopted for the Privileges in question, then the Credentials Committee will consider the Hospital's capability of providing the services or procedures and, in appropriate cases, will recommend standards that should apply to the request for Privileges in that specialty.

C. In developing such standards, the Credentials Committee will conduct research and consult with experts in the specialty, including the chief and members of applicable departments of the Hospital, other members of the Medical Staff, and/or physicians from other hospitals or health care facilities.

D. The Credentials Committee will develop recommendations regarding the following:

(i) The apparent patient care need for the services or procedures;

(ii) Whether the Hospital has the facilities, equipment and personnel necessary to enable Practitioners to exercise the Privileges in question;

(iii) Whether the Practitioner's exercise of these Privileges would meet or exceed the current standard of practice, as evidenced by his/her education, training and experience to perform the services or procedures; and

(iv) The extent of monitoring or supervision that should occur.

E. The Credentials Committee shall forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

7.3 SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

Dentists shall be assigned to the Department of Surgery, unless otherwise decided by the MEC. Dentists may write orders and prescribe medication within the limits of their licensure and Clinical Privileges. Except as provided with respect to oral and maxillofacial surgeons, surgical procedures performed by dentists shall be under the supervision of the Chief of the Department of Surgery. All dental patients shall receive the same basic medical appraisal as other patients. Except as provided with respect to oral and maxillofacial surgeons an attending Practitioner shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

7.4 SPECIAL CONDITIONS FOR PODIATRY PRIVILEGES

Podiatrists shall be assigned to the Department of Surgery, unless otherwise decided by the MEC. Podiatrists may write orders and prescribe medication within the limits of their licensure and Clinical Privileges. All podiatric patients shall be admitted and discharged by an attending Practitioner who is a member of the Medical Staff and shall receive the same basic history and physical appraisal as other patients. The admitting physician member of the Medical Staff shall be the attending Practitioner responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of any proposed surgical procedure on the total health status of the patient.

7.5 SPECIAL CONDITIONS FOR RECOGNIZED MEDICAL AFFILIATE SERVICES

Requests to perform specified patient care services from Recognized Medical Affiliates shall be evaluated in the manner specified in Section 7.2.

7.6 TEMPORARY PRIVILEGES

7.6-1 Circumstances. Upon the written confirmation of the chairman of the department where the Privileges will be exercised or his or her designee, the chairman of the Credentials Committee or his or her designee, and the Chairman of the Medical Executive Committee or his or her designee, the President may grant Temporary Privileges in the following circumstances:

A. Care of Specific Patients. In circumstances in which an important patient care need mandates that a Practitioner be given immediate authorization to practice in the Hospital, an appropriately licensed Practitioner may be

granted Temporary Privileges for the care of one (1) or more specific patients. Such Privileges shall be restricted to a specific period of time relating to the treatment needs of these patients. If the Practitioner seeks to treat additional patients, such Practitioner shall be required to apply for membership on the Medical Staff before being allowed to do so.

B. While Awaiting Approval by the MEC and Governing Board. After submitting a complete written application for membership on the Medical Staff, containing the core information that is required as set forth in Section 6.2 of these Bylaws, Rules and Regulations, a Practitioner may be granted Temporary Privileges while awaiting the review and approval of his/her application by the Medical Executive Committee and Board. Temporary Privileges will not be awarded if serious questions are raised by the application, particularly as pertains to matters affecting the physician's licensure, registration, or privileges at another hospital. When Temporary Privileges are awarded, they will be in effect for no more than one hundred twenty (120) days under these circumstances.

C. Substitutions/Locums Tenens. An appropriately licensed Practitioner who wishes to serve as a temporary substitute for a member of the Medical Staff or to fill a temporary need for particular medical services may be granted Temporary Privileges for not more than thirty (30) days provided that there is a patient care need for his/her services and this is verified by the MEC and the President and that his/her credentials have first been reviewed by the chief of the department concerned or his or her designee and by the chairman of the Medical Executive Committee or his or her designee. Privileges under this category may be renewed once. The chief of the department concerned shall assume responsibility for monitoring the number of days in which the Practitioner exercises Temporary Privileges. It is understood that Practitioners who receive Temporary Privileges under this category will not be members of the Medical Staff or have the Prerogatives of such membership. However, nothing in this Section shall preclude a Practitioner from applying for Clinical Privileges to serve on the Active Staff or Courtesy Staff after the Practitioner's Temporary Privileges have lapsed.

7.6-2 Conditions. Temporary Privileges shall not be used in other situations, such as when a Practitioner's application for initial appointment or reappointment is incomplete or when the information in an application has not been verified. Temporary Privileges as set forth above shall be granted only when the information available reasonably supports a favorable determination regarding the Practitioner's qualifications, ability and judgment to exercise the Privileges requested, and only after the Practitioner has satisfied the requirements regarding professional liability insurance coverage and other essential matters. Before Temporary Privileges are granted, the Practitioner must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, Rules and

Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her Temporary Privileges.

7.6-3 Notice of Decision. Notice of the decision to award a Practitioner Temporary Privileges shall be given through the President to the Medical Staff Services Coordinator, the chairmen of the Medical Executive Committee and the Credentials Committee, and the Practitioner by means of Special Notice.

7.6-4 Termination. Upon the discovery of any information or the occurrence of any event relating to or bearing negatively upon a Practitioner's qualifications or ability to exercise any or all of the Temporary Privileges granted, the President may, after consultation with the chief of the department responsible for supervision of the Practitioner or the Chairman of the Medical Executive Committee, terminate any or all of such Practitioner's Temporary Privileges, provided that where the life or well-being of a patient is determined to be endangered by continued treatment by the Practitioner, termination may be effected by any person entitled to impose suspensions under ARTICLE VIII. In the event of any such termination of Temporary Privileges, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the chief of the department responsible for supervision. The wishes of the patient shall be considered, where feasible, in designating another Practitioner.

7.6-5 Rights of the Practitioner. A Practitioner shall not be entitled to the procedural rights afforded by ARTICLE IX due to any refusal to grant Temporary Privileges.

7.7 EMERGENCY PRIVILEGES

7.7-1 Specific Patients. In an emergency affecting a specific patient, any Practitioner, to the degree permitted by his/her license, and regardless of Medical Staff status or Clinical Privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything reasonably and practically possible under the circumstances to provide emergency treatment and care as may be appropriate until the emergent status is eliminated. For purposes of this Section, "emergency" is defined as a situation in which, based upon competent medical judgment, proposed medical or surgical treatment or procedures are immediately or imminently necessary and any delay may result in serious or permanent harm to a patient, or in which the life of a patient is in immediate danger and any delay in providing treatment could reasonably be expected to jeopardize the life, health or limb of the patient or result in disfigurement or impairment of faculties.

7.7-2 Disasters. In the event of a disaster, physicians who do not have Privileges at the Hospital may be authorized through an award of temporary privileges by the Chairman of the Medical Executive Committee, the President, or their designees to provide assistance. In determining the procedures and scope of such authorization, disaster protocols developed by the Hospital shall be followed.

7.8 MAINTENANCE OF THE MEDICAL STAFF CREDENTIALS FILE

All information received during the credentialing process, whether from a Practitioner or others, shall be kept and compiled in a single Credentials File. Each Credentials File shall be subdivided into documentation, correspondence, and confidential peer review information. All peer review information, and information relevant to professional conduct, performance, competence, or the health care provided to any patient, must be kept in the Credentials File in a closed or sealed section or envelope labeled "Confidential-Peer Review." The confidential sections of the Credentials File shall only be accessible by the applicable Department Chief, Chief of Staff, Chair of the Continuous Quality Improvement Committee, Chair of the Credentials Committee, and the President, or each of their designees, and the subject Practitioner, or as required by law. If information in a Practitioner's Credentials File was submitted with an expectation of confidentiality, then the name of the individual and other information that may reveal his/her identity may be withheld from the Practitioner except as required under the Fair Hearing Plan. The addition of information to a Practitioner's Credentials File, other than information submitted by the Practitioner in the context of applying for Medical Staff membership and Privileges or renewal thereof, requires written notification to the subject Practitioner. The following procedures shall apply to actions relating to insertion of information into a Practitioner's Credentials File:

A. Pursuant to Article VIII, Section 8.1-1, any person may provide information to the Medical Staff about the conduct, performance or competence of a Practitioner.

B. Information pertaining to a Practitioner shall be communicated to the Chief of Staff or the respective department chief or division chair. The department chief, division chair and Chief of Staff shall review such information and decide whether the matter should receive further consideration or investigation by or through a department, division or committee of the Medical Staff, and whether collegial intervention or corrective action should be taken. Before placing such information in a Practitioner's Credentials File, the Practitioner shall be notified in writing of the substance of the information and offered the opportunity to submit a written rebuttal.

C. Upon receipt and review of a written rebuttal from the Practitioner, a decision will be made by the respective department chief and Chief of Staff to:

(i) not add the information to the Practitioner's Credentials File;

(ii) add the information to the Credentials File along with the notation that no further review or other action is warranted; or

(iii) add the information to the Credentials File with a notation as to what other action was or will be taken, including whether a request has been made to the Medical Executive Committee for an investigation as provided in these Bylaws.

D. The decision shall be reported to the Medical Executive Committee by the Chief of Staff. If the department chief and the Chief of Staff are unable to reach a decision as to the appropriate action that should be taken in accordance with Section 7.8C, then the matter shall be referred to the Medical Executive Committee, which will reach a decision by a majority vote.

E. The Practitioner will be given written notice of the decision and informed of his/her rights, if any, under the Fair Hearing Plan as outlined in the appendix to the Medical Staff Bylaws and Rules and Regulations.

ARTICLE VIII. COLLEGIAL INTERVENTION AND CORRECTIVE ACTION

8.1 INITIATION

8.1-1 Criteria for Initiation. Any person may provide information to the President or a member of the Medical Executive Committee about the conduct, performance, or competence of a Practitioner. When reliable information indicates that a Practitioner's actions, demeanor or conduct has been or is likely to be:

A. detrimental to patient safety or the delivery of quality patient care within the Hospital,

B. unethical or unlawful,

C. contrary to the Medical Staff Bylaws or Rules and Regulations or Hospital policies; or

D. inconsistent with applicable professional standards,

then collegial intervention or corrective action against such Practitioner may be initiated by the Chief of Staff, the chief of the appropriate department or chair of the appropriate division of the Medical Staff, the President, or the Board, as set forth in this Article and other applicable requirements of these Bylaws and credentialing policies.

8.1-2 Requests and Notices. If any person has concern about the professional performance, conduct or competence of a Practitioner, he/she may notify the Chief of Staff, the chief of the appropriate department or chair of the appropriate division, or the President. Such notification should be supported by references to the specific activities or conduct which constitute the basis for the concern. A

department chief or division chair who receives such comments shall notify the Chief of Staff. The Chief of Staff shall notify the President of requests for collegial intervention or corrective action and shall keep him fully informed of all recommendations that are made and actions that are taken in conjunction therewith. The Chief of Staff shall be responsible for assuring that written information that is created or collected during the process is maintained, as appropriate, in the Practitioner's Credentials File.

8.1-3 Review by Department. When the Chief of Staff is notified of a concern about the performance, conduct or competence of a Practitioner, he/she shall take appropriate actions in the matter, which may include forwarding the information to the chief of the department in which the questioned activities or conduct occurred or the chief of the department with which the Practitioner is affiliated. The department chief shall review the matter or designate another Practitioner from the applicable department or division to review the matter. Within thirty (30) days after the receipt of the request, the department chief shall make a report to the Medical Executive Committee, through the Chief of Staff, and may make a recommendation about whether any further investigation should occur or other action should be taken in the matter.

8.1-4 Medical Executive Committee Action. A matter that has been reviewed as described in Section 8.1-3 shall be reported to the MEC at its next meeting. After considering the matter, the MEC may, without limitation:

A. take no further action in the matter;

B. defer a recommendation or other action until there has been an investigation of the matter by a department or committee of the Medical Staff or by another consultant to the MEC;

C. refer the matter to the appropriate department chief, division chair or Chief of Staff for collegial intervention, such as an oral or written reprimand or warning, education, or counseling, although nothing herein shall be deemed to preclude the Chief of Staff or a department chief or division chair from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the Credentials File;

D. recommend that particular conditions be imposed upon the Practitioner's continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, establishing requirements for monitoring, mandatory consultation, mentoring, proctoring, or co-admissions;

E. recommend conditions or limitations of any Privileges or Prerogatives related to the Staff member's delivery of patient care or other matters that are of concern;

F. recommend suspension or revocation of Medical Staff membership and/or particular Clinical Privileges; or

G. make such other recommendations or take such other actions as are deemed appropriate under the circumstances, consistent with these Bylaws and applicable credentialing policies.

8.1-5 Procedural Rights. Any recommendation or action of the Medical Executive Committee under Section 8.1-4(D), (E) or (F) shall entitle the subject Practitioner to exercise the procedural rights provided in ARTICLE IX, and the Fair Hearing Plan appended hereto.

8.1-6 Other Action. If the Medical Executive Committee's recommended action is as provided in Section 8.1-4(D), (E) or (F), then such recommendation and all supporting documentation shall be forwarded to the Board for Board action.

8.2 SUMMARY SUSPENSION OF PRIVILEGES

8.2-1 Criteria. Whenever, in the judgment of the Chief of Staff or President, the conduct or performance of a Practitioner requires that immediate action be taken to protect the life or to reduce the substantial likelihood of immediate injury or harm to the health or safety of any patient, employee or other person in the Hospital, the Chief of Staff or the President shall have the authority to suspend the Medical Staff membership or all or any portion of the Clinical Privileges of such Practitioner. Such suspension shall become effective immediately upon providing verbal or written notice to the Practitioner and shall continue in effect until the next MEC meeting, unless the President sooner takes action to modify or rescind the suspension. The Chief of Staff or President shall give Special Notice of such suspension and any subsequent actions that are taken in the matter to the Practitioner as soon as is reasonably possible, but in any event prior to the MEC meeting at which the matter will be reviewed as set forth in Section 8.2-2 below.

8.2-2 Medical Executive Committee Action. When a Practitioner has been suspended as set forth in Section 8.2-1 above, the matter will be reviewed by the MEC at its next regularly scheduled meeting or at a special meeting called for this purpose, but in any event within thirty (30) days of the imposition of the suspension. The Medical Executive Committee shall review the reasons for the suspension and consider the action taken and shall recommend continuation, modification or termination of the suspension to the Board. Notwithstanding the recommendations of the MEC, the President may rescind a suspension or may continue a suspension in effect pending review by the Board, and subject to the Practitioner's exercise of

procedural rights as set forth in these Bylaws and the Fair Hearing Plan appended hereto.

8.2-3 Procedural Rights. Imposition of a suspension of the Medical Staff membership or Clinical Privileges of a Practitioner or a recommendation by the MEC to suspend the membership and/or Clinical Privileges of a Practitioner shall entitle the Practitioner to exercise the procedural rights provided in ARTICLE IX, and the Fair Hearing Plan. Except as provided in Section 8.2-2 above, a suspension as approved or as modified by recommendation of the Medical Executive Committee shall remain in effect pending a final decision by the Board.

8.3 RELINQUISHMENT OF PRIVILEGES

8.3-1 License. A Practitioner or Affiliate whose license, certificate or other legal credential authorizing him/her to practice in Missouri is revoked or suspended shall be subject to the immediate, automatic relinquishment of his/her Medical Staff membership and Clinical Privileges in the Hospital for the period of the licensure suspension or revocation, if and to the extent that such revocation or suspension relates to the Clinical Privileges of the Practitioner or Affiliate, and until such license, certificate, or other credential has been reinstated. The failure of a Practitioner or Affiliate to provide the Hospital complete, current information about any action that has been taken with respect to his/her license, certificate or other professional credential shall be cause for the immediate, automatic relinquishment of the Medical Staff membership and Clinical Privileges of the Practitioner or Affiliate pending compliance. The Medical Executive Committee or President may make such recommendations or take such further action as may be appropriate under the facts, as authorized by these Bylaws and applicable credentialing policies, and the Practitioner shall be entitled to exercise such procedural rights as are consistent with an adverse action as defined in the Fair Hearing Plan.

8.3-2 Drug Enforcement Agency (DEA) and Bureau of Narcotics and Dangerous Drugs (BNDD) Number(s). A Practitioner whose DEA or BNDD number is revoked or suspended in whole or in part shall be subject to the immediate, automatic relinquishment of his/her right to prescribe medications covered by such action for the period of such suspension or revocation. Upon notice of such occurrence, the Medical Executive Committee shall convene to review and consider the facts under which the DEA or BNDD number was revoked or suspended by the DEA or BNDD. The Medical Executive Committee may then make such recommendations or take such further action hereunder as may be appropriate under the facts, as authorized by these Bylaws and applicable credentialing policies. Unless excused by the Medical Executive Committee upon a showing of good cause, failure to provide current DEA or BNDD number information to the Hospital, through the Medical Staff Services Office shall be cause for immediate, automatic relinquishment of Medical Staff membership and Clinical Privileges of the Practitioner pending compliance. This Section 8.3-2 shall have no application

to any Practitioner who, with the prior approval of the Medical Executive Committee, voluntarily elects not to maintain DEA or BNDD capabilities. The Medical Executive Committee or President may make such recommendations or take such further action as may be appropriate under the facts, as authorized by these Bylaws and applicable credentialing policies, and the Practitioner shall be entitled to exercise such procedural rights as are consistent with an adverse action as defined in the Fair Hearing Plan.

8.3-3 Failure to Satisfy Professional Liability Insurance Requirement. A Practitioner shall cause evidence of his/her professional liability insurance coverage as required by these Bylaws to be filed with the Hospital, through the Medical Staff Services Office. Unless excused by the Medical Executive Committee and the President upon a showing of good cause, failure to provide such current information at all times shall subject the Practitioner to the immediate, automatic relinquishment of his/her Medical Staff membership and Clinical Privileges pending compliance. The Medical Executive Committee or President may make such recommendations or take such further action as may be appropriate under the facts, as authorized by these Bylaws and applicable credentialing policies, and the Practitioner shall be entitled to exercise such procedural rights as are consistent with an adverse action as defined by the Fair Hearing Plan.

8.3-4 Failure to Satisfy Information or Special Appearance Requirement. If a Practitioner fails, without good cause, and after receiving reasonable notice, to (a) meet with the MEC, the Chief of Staff, or the President to discuss concerns about his/her professional performance or conduct, or (b) provide information reasonably necessary to assess the Practitioner's professional conduct or performance, then this shall be cause for the immediate, automatic relinquishment of his/her Medical Staff membership and Clinical Privileges pending compliance.

8.3-5 Failure to Maintain Medical Records. Practitioners shall complete all patient medical records within thirty (30) days following discharge or within such lesser period as is required by law or by the Medical Staff Bylaws and Rules and Regulations. A patient record which remains incomplete for more than the allowable number of days following discharge shall be considered delinquent. The Hospital, through the Medical Records Department, shall provide written notice to the subject Practitioner promptly of delinquent records. If a Practitioner fails to complete the records within seven days following such notice, then the matter may be referred to the Chief of Staff for further consideration. The MEC, through the Chief of Staff, may provide written notice to the Practitioner that his/her failure to complete medical records within seven days of providing such notice will be cause for the relinquishment of the Practitioner's Medical Staff membership and Clinical Privileges, pending compliance. Best efforts will be made to also provide verbal notice to the Practitioner before calling for the relinquishment of his/her Medical Staff membership and Clinical Privileges.

8.4 PRACTITIONER HEALTH

8.4-1 Notwithstanding the foregoing Sections in this Article VIII, the Medical Staff will develop and implement procedures for identifying and managing matters pertaining to physician health that are separate from the corrective action process. The purpose of these procedures will be to facilitate the diagnosis, treatment, and rehabilitation of Practitioners who suffer from physical or psychological conditions that may cause or lead to impairments such that affected Practitioners will retain or regain optimal professional functioning. These procedures may apply as well in appropriate cases to Recognized Medical Affiliates.

8.4-2 The procedures for identifying and managing matters of individual Practitioner health should include the following components:

A. Information will be provided about illnesses and other physical conditions that may cause or lead to physical, psychological or emotional impairments. This information may be provided in writing and/or in training sessions that are offered by or through the Medical Staff, the various departments or divisions, or other professional organizations such as the Missouri Physician's Health Program.

B. A referral process will be developed that encourages self-referrals and referrals by others of Practitioners who may be impaired. The existence and nature of this referral process will be communicated to members of the Medical Staff and the Hospital staff.

C. The credibility of complaints, allegations, and concerns about the practices of specific Practitioners will be investigated by members of the Medical Staff and Hospital staff, as appropriate, who are designated to do so by the Chief of Staff and President.

D. When the circumstances warrant this response, Practitioners will be referred to internal or external resources for diagnosis and treatment of conditions that may cause or lead to impairments. Such referrals may be to resources that are offered by or are made available through the Missouri Physician's Health Program or such other programs as are known to the Medical Executive Committee or the affected Practitioner.

E. Procedures will be established to ensure that the confidentiality of Practitioners seeking referral or having been referred for assistance is maintained, except as required by law or ethical obligations. These procedures will include communicating information only on a need-to-know basis to members of the Medical Staff and Hospital staff and minimizing the number of individuals to whom information about a Practitioner is made known.

F. The practices and behavior of affected Practitioners will be monitored, in the interest of ensuring the safety of patients until the rehabilitation process is complete.

8.4-3 In determining whether a Practitioner has an impairment that affects his/her medical practice within the Hospital, the Chief of Staff or his/her designee or the President may request that a Practitioner be evaluated by a professional with expertise in the relevant area of concern. Usually, such evaluation will be by an individual who is not affiliated with the Hospital. The results of the evaluation will be provided to the Chief of Staff and the President.

8.4-4 If, at any time, either a Practitioner is uncooperative with the efforts described above or there is concern that the Practitioner may not be able to safely perform the Privileges that he has been granted at the Hospital, then the matter will be referred to the Medical Executive Committee for further review and appropriate action. In these circumstances, a report will be prepared that describes the issues or incidents that have raised concerns about the Practitioner, the steps that have been taken to address these concerns, and the reason(s) why the matter now is being referred to the Medical Executive Committee for further review and action.

ARTICLE IX. INTERVIEWS, HEARINGS AND APPELLATE REVIEW

9.1 INTERVIEWS

When the Medical Executive Committee or the Board is considering the initiation of an adverse recommendation concerning a Practitioner as defined in the Fair Hearing Plan, the MEC or Board may request that the Practitioner meet with the MEC or Board. This meeting shall not be in the nature of a hearing, shall be preliminary in nature, shall not include attorneys or other persons, and shall not be conducted according to the procedural rules provided for hearings. The Practitioner shall be informed of the general nature of the MEC's concerns and may present information relevant thereto. A record of such interview may be made by the Medical Executive Committee in its minutes.

9.2 HEARINGS AND APPELLATE REVIEW

9.2-1 Adverse Medical Executive Committee Recommendation. When any Practitioner receives Special Notice of an adverse recommendation of the Medical Executive Committee in accordance with the Fair Hearing Plan, he/she shall be entitled, upon written request, to a hearing before an ad hoc hearing committee of the Medical Staff that has been appointed by the Chief of Staff. If the recommendation of the Medical Executive Committee following such hearing is adverse to the Practitioner, then he/she shall be entitled, upon written request, to an appellate review by the Board before a final decision is made and action is taken against his/her Medical Staff membership and Clinical Privileges, except as otherwise provided in these Bylaws.

9.2-2 Adverse Board Decision. When any Practitioner receives Special Notice of an adverse decision by the Board that either reverses a favorable recommendation by the Medical Executive Committee or was made on the Board's own initiative without benefit of a prior recommendation by the MEC, such Practitioner shall be entitled, upon written request, to a hearing by an ad hoc hearing committee of the Medical Staff that has been appointed by the Chief of Staff. If such hearing does not result in a favorable recommendation, the Practitioner shall then be entitled, upon written request, to an appellate review by the Board before a final decision is made and action is taken against his/her Medical Staff membership and Clinical Privileges, except as otherwise provided in these Bylaws.

9.2-3 Procedure and Process. All hearings and appellate reviews shall be conducted in accordance with the procedures set forth in the Fair Hearing Plan appended to these Bylaws.

9.2-4 Exceptions. The issuance of a warning, a letter of admonition, a letter of reprimand, or any other action except those specified in the Medical Staff Bylaws and the Fair Hearing Plan shall not give rise to any right to a hearing or appellate review.

ARTICLE X. STAFF DEPARTMENTS

10.1 ORGANIZATION OF STAFF DEPARTMENTS

Each department shall be organized as a part of the Medical Staff and shall have a chief selected as set forth in section 11.2-1B of these Bylaws, who shall exercise the authority, duties, and responsibilities set forth in Section 11.2-1E.

10.2 DESIGNATION

10.2-1 Departments and Divisions. The departments of the Medical Staff are: Surgery, Orthopaedic Surgery, Obstetrics and Gynecology, Family Medicine, Pediatrics, Anesthesiology, Pathology, Radiology, Emergency Medicine, and Internal Medicine.

10.2-2 Future Departments. When deemed appropriate, the Medical Executive Committee and the Board, by joint action, may create, eliminate, divide or combine departments or divisions.

10.3 ASSIGNMENT TO DEPARTMENTS

The Medical Executive Committee, after consideration of recommendations transmitted through the Credentials Committee, shall recommend departmental assignments for all Medical Staff members. Each member of the Medical Staff shall be assigned membership in at least one (1) department, but may be granted membership and/or Clinical Privileges in one (1) or more departments. Family Medicine Practitioners and other Practitioners

may have Clinical Privileges in more than one (1) department in accordance with their education, training and experience. Practitioners who are assigned to a division shall be members of the related department. Prerogatives within any department or division shall be subject to the rules and regulations of that department or division and the authority of the department chief or division chair, except to the extent that the Bylaws set forth Prerogatives that may be exercised by Practitioners on the Medical Staff.

10.4 FUNCTIONS OF DEPARTMENTS AND DIVISIONS

10.4-1 General. In the performance of functions as set forth herein, each department shall be accountable to the Medical Executive Committee and each division shall be accountable to the Medical Executive Committee and the department of which it is a part. The primary responsibility of each department shall be to implement and conduct specific review and evaluation activities which contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. In the discharge of this responsibility, each department may be expected to perform any of the following functions, as requested by the MEC. Divisions may perform any of these functions, as determined by the chief of the department or the MEC:

A. review and evaluate clinical work performed within the department to verify adherence to Medical Staff policies and procedures and accepted standards of clinical practice and formulate departmental policies that are reasonably necessary for the proper discharge of this responsibility;

B. recommend to the Credentials Committee and the Medical Executive Committee guidelines for granting Clinical Privileges and for exercising specified Prerogatives within the department;

C. conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to clinical practice within the department;

D. evaluate and make recommendations to the Credentials Committee and the MEC regarding the qualifications of applicants seeking appointment or reappointment to the Medical Staff and Privileges within the department;

E. monitor, on a continuing and concurrent basis through chart reviews, direct observation and other appropriate means as approved by the MEC, compliance of Practitioners in the department with the following:

(i) Medical Staff and Hospital and departmental policies and procedures;

(ii) requirements for accepting “on call” responsibilities and requests for consultations;

(iii) standards of clinical practice and the quality and appropriateness of patient care; and

(iv) fire and other regulations and policies designed to promote patient safety;

F. coordinate patient care provided by department members with nursing and ancillary patient care services and with administrative support services;

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

H. submit written reports to the Medical Executive Committee as requested concerning:

(i) findings of the department's review and evaluation activities regarding Practitioners, actions taken thereon, and the results of such actions;

(ii) recommendations for maintaining and improving the quality of care provided in the department and the Hospital;

(iii) new departmental rules and guidelines affecting patient care services or Practitioner practice patterns in the department; and

(iv) such other matters as may be requested from time to time by the Medical Executive Committee; and

I. review and consider patient care monitoring findings and the results of the department's review, evaluation and education activities and perform or receive reports on other department and Staff functions.

10.4-2 Meetings. Departments and divisions of the Medical Staff will meet at least quarterly except as otherwise agreed or required by the Medical Executive Committee or the Chief of Staff.

ARTICLE XI. OFFICERS

11.1 OFFICERS OF THE MEDICAL STAFF

11.1-1 Identification. The officers of the Medical Staff shall be:

A. Chief of Staff,

B. Vice Chief of Staff, and

C. Secretary-Treasurer.

11.1-2 Qualifications. Officers of the Medical Staff must be members of the Active or Senior Active Staff at the time of their nomination, election, succession or appointment to office and must remain members in good standing of the Active or Senior Active Staff during their terms of office.

11.1-3 Nominations.

A. Selection by Nominating Committee. The Nominating Committee shall consist of the Chief of Staff, the Vice Chief of Staff, and the immediate past Chief of Staff. The Chief of Staff will chair the Committee. The President shall be an ex officio member of the Nominating Committee. The Nominating Committee shall convene prior to the fourth quarterly meeting and shall recommend a qualified nominee for the office of Secretary-Treasurer. In selecting a candidate for this office, the Nominating Committee shall consult with members of the Medical Staff and Hospital administration concerning the qualifications and acceptability of prospective nominees.

B. Process of Appointment. The name of the nominee for the office of Secretary-Treasurer shall be reported to the Medical Staff at least fourteen (14) days prior to the fourth quarterly meeting. This nomination must be ratified by a majority vote of the members of the Medical Staff at the quarterly meeting. If the nominee is not approved by the Medical Staff, then the matter will be referred to the Nominating Committee, which will select another nominee. The name of the new nominee will be reported and submitted for a vote of the Medical Staff at the next quarterly meeting, as provided above.

11.1-4 Election. Election of officers shall take place at the general Medical Staff meeting in the fourth quarter of each year. Only Staff members who are accorded the Prerogative to vote at general meetings of the Medical Staff shall be eligible to vote. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast.

11.1-5 Exceptions. Sections 11.1-3 and 11.1-4 shall not apply to the offices of Chief of Staff and Vice Chief of Staff. After serving a two (2) year term in each office as set forth in Section 11.1-6 of these Bylaws, the Secretary-Treasurer shall succeed to the office of Vice Chief of Staff and the Vice Chief of Staff shall succeed to the office of Chief of Staff. After serving a two-year term, it is expected that the Chief of Staff will succeed to the positions of chair of the Credentials Committee and the Practitioners' Health Committee.

11.1-6 Term of Elected Office. Each officer shall serve a two (2) year term in each of the offices and positions noted in Section 11.1-5 of these Bylaws. Each office shall commence on January 1 following the fourth quarterly meeting. Each officer shall serve until the end of his/her term or until a successor is elected or succeeds to office.

11.1-7 Removal. The death or serious illness of an officer or the failure of an officer to maintain Active or Senior Active Medical Staff status shall immediately create a vacancy in the office involved. Failure of an officer to discharge duties in a professional and competent manner shall be grounds for removal from office. Such removal may be accomplished by a majority vote of the Medical Executive Committee or the Board or by a two-thirds vote of the voting members of the Medical Staff. The Practitioner will be given at least ten (10) days' written notice that such removal action may occur. The Practitioner will be allowed to attend the meeting and to address the MEC or the Board or the Medical Staff prior to a vote on his/her removal from office.

11.1-8 Vacancies in Elected Office. A vacancy in the office of Secretary-Treasurer shall be filled by the Medical Executive Committee until the next general meeting of the Medical Staff, at which time the appointee or other nominee will be presented for a vote of the Medical Staff. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve out the remaining term. If there is a vacancy in the office of Vice Chief of Staff, the Secretary-Treasurer shall serve out the remaining term.

11.1-9 Duties of Elected Officers.

A. Chief of Staff. The Chief of Staff shall serve as the Chief Administrative Officer of the Medical Staff. The Chief of Staff shall serve as ex officio Medical Staff liaison to the Board and shall:

(i) assist in coordinating the activities and concerns of the Hospital administration and nursing and other patient care services with those of the Medical Staff;

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

(iii) serve as Chairman of the Medical Executive Committee and the Nominating Committee and as an ex officio member of all committees;

(iv) serve, as immediate past Chief of Staff, as Chairman of the Credentials Committee and the Practitioners' Health Committee;

(v) be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where indicated, and for Medical Staff compliance with procedural safeguards in all instances where collegial intervention or corrective action has been requested against a Practitioner;

(vi) except as otherwise provided in these Bylaws, appoint committee members to all standing, special and disciplinary Medical Staff committees except the Medical Executive Committee;

(vii) participate in the selection of department chiefs and division chairs;

(viii) develop and implement, in cooperation with the Hospital administration and department chiefs, methods for delineation of Privileges, continuing education programs, utilization review, concurrent monitoring of practice, and retrospective patient care monitoring;

(ix) communicate and represent the opinions, policies, concerns and needs of the Medical Staff to the Board, the President, and other officers of the Medical Staff;

(x) be accountable to the Board, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of patient care monitoring and other quality maintenance functions delegated to the Staff; and

(xi) be the spokesperson for the Medical Staff in its external professional and public relations.

B. Vice Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee. In the temporary absence of the Chief of Staff, he/she shall assume all of the duties and have the authority of the Chief of Staff. He/she shall serve as chair of the Continuous Quality Improvement Committee and as a member of the Nominating Committee and shall perform such additional duties as may be assigned by the Chief of Staff or the Medical Executive Committee.

C. Secretary-Treasurer. The Secretary-Treasurer shall be a member of the Medical Executive Committee, and shall:

(i) cause notice of all Staff meetings to issue upon order of the appropriate authority;

(ii) cause accurate and complete minutes for all meetings of the Medical Executive Committee and general and special meetings of the Medical Staff to be prepared;

(iii) attend to and supervise all correspondence of the Medical Staff;

(iv) supervise the collection of Medical Staff dues and have responsibility for the custody of all funds of the Medical Staff;

(v) oversee the accurate accounting for all Medical Staff funds and report the financial status and financial transactions of the Staff at least semiannually;

(vi) be responsible for maintaining a roster of members of the Medical Staff; and

(vii) perform such other duties as ordinarily pertain to the office, and in the absence of the Chief and Vice Chief of Staff, assume the duties of the presiding Medical Staff officer.

11.2 OTHER OFFICIALS OF THE STAFF

11.2-1 Department Chief.

A. Qualifications. Each chief shall be a member of the Active Staff and shall be certified by an appropriate specialty board or demonstrate through the privilege delineation process that he/she is otherwise qualified by training, experience and demonstrated ability to serve as department chief. Each chief shall be willing and able to discharge faithfully the functions of department chiefs. If a department chief is not board certified, affirmative consideration of his/her training, experience and demonstrated ability should be considered and documented in his/her Medical Staff Credentials File.

B. Selection. Notwithstanding anything to the contrary in these Bylaws, each chief shall be elected by the members of the department who are on the Active or Senior Active Staff, subject to the consent of the Chief of Staff and Medical Executive Committee. Election of a department chief may occur at any regularly scheduled meeting of the department, if the members of the department have received notice of the election. Selection of a chief of a department will be pursuant to a majority vote of the Practitioners present and eligible to vote.

C. Term of Office. A department chief shall serve a term of up to two (2) years, commencing on his/her selection as referenced in Section 11.2-1B

and continuing until a successor is chosen. A department chief shall be eligible to succeed himself/herself.

D. Removal. Failure to maintain Active or Senior Active Medical Staff status shall immediately create a vacancy in the position of department chief. Failure to discharge the duties of department chief in a professional and competent manner shall be grounds for removal. Removal of a chief during his/her term may be initiated by a two-thirds (2/3) majority vote of all Active and Senior Active Staff members in the department. Removal shall not be effective unless and until it has been ratified by majority vote of the Medical Executive Committee or the Board. Removal may also be accomplished by majority vote of the Medical Executive Committee acting upon its own recommendation. The Practitioner will be given at least ten (10) days' written notice that such removal action may occur. The Practitioner will be allowed to address the MEC or the Board prior to a vote on his/her removal from the position.

E. Duties. Each chief shall:

(i) account to the Medical Executive Committee for all professional and administrative activities within the department, for the continuous assessment and improvement of the quality of care, treatment, and services rendered by members of the department, and for the effective conduct of performance evaluation and other quality control maintenance functions delegated to the department;

(ii) develop and implement departmental policies, procedures, and programs for Privileges delineation, orientation, continuing medical education, utilization review, concurrent monitoring of practice, retrospective patient care monitoring, and others as may be necessary to guide and support the provision of care, treatment, and services;

(iii) be a member of the Medical Executive Committee providing guidance on the overall medical policies of the Hospital and specific recommendations and suggestions regarding the department, including the qualifications, competence and number of other service personnel who provide patient care within the department;

(iv) transmit to the appropriate authorities when requested the department's recommendations concerning appointment and classification, reappointment, Clinical Privileges or specified services, collegial intervention and corrective action with respect to Practitioners in the department;

(v) appoint such committees as are necessary to conduct the functions of the department and designate a chairman for each (e.g. examples of such subcommittees are transfusion, surgical case review, and radiation safety);

(vi) enforce the Hospital and Medical Staff Bylaws, Rules and Regulations and polices within the department, including initiating collegial intervention, corrective action and investigation of clinical performance and ordering required consultations, with the concurrence of the Medical Executive Committee;

(vii) implement within the department actions taken by the Medical Executive Committee;

(viii) participate in every phase of administration of the department through cooperation with the Hospital administration in matters affecting patient care, including personnel, space, equipment, supplies and other resource needs, regulations, standing orders, and clinical techniques;

(ix) assist in the preparation of such reports pertaining to the department as may be required by the Medical Executive Committee;

(x) maintain continuing review of the professional performance of all Practitioners with Clinical Privileges in the department and report findings to the Medical Executive Committee, as requested;

(xi) assess and recommend off-site sources for patient care services not otherwise provided by the Hospital;

(xii) integrate the department into the primary functions of the Hospital and coordinate and integrate inter and intra-departmental functions;

(xiii) perform such other duties incident to the position as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee; and

(xiv) recommend the criteria for Clinical Privileges that are relevant to the care provided in the department.

11.2-2 Division Chair.

A. Qualifications. Each chair of a division shall have the qualifications required of a chief of a department, as set forth in Section 11.2-1A of these Bylaws.

B. Selection. Each division chair shall be appointed by the chief of the related department, subject to the concurrence of the Chief of Staff and the Medical Executive Committee.

C. Term of Office. A division chair shall serve a term of up to two (2) years, commencing on his/her appointment and continuing until a successor is chosen. A division chair shall be eligible to succeed himself/herself.

D. Removal. Failure to maintain Active or Senior Active Medical Staff status shall immediately create a vacancy in the position of division chair. Failure to discharge the duties of a division chair in a professional and competent manner shall be grounds for removal. Removal may be initiated by the chief of the related department or by the Medical Executive Committee and requires a majority vote of the MEC. The Practitioner will be given at least ten (10) days' written notice that such removal action may occur and will be allowed to address the MEC prior to a vote on his/her removal from the position.

E. Duties. Each chair of a division shall be accountable to the chief of the related department and the Medical Executive Committee to carry out such functions as are requested, consistent with Section 11.2-1E.

ARTICLE XII. COMMITTEES AND FUNCTIONS

12.1 DESIGNATION

The responsibilities and functioning of the Medical Staff shall be overseen by a Medical Executive Committee and such other standing and special committees of the Staff responsible to the Medical Executive Committee as may from time to time be necessary and appropriate to perform Staff functions as set forth in Sections 12.5 and 12.6 of these Bylaws and as may be required from time to time. Whenever it is necessary that a function be performed, or that a report or recommendation be prepared by the Medical Staff, the Medical Executive Committee shall perform such function or assign the task either to a standing committee as established by these Bylaws or to a special committee appointed by the Chief of Staff. When the Medical Executive Committee or Chief of Staff assigns a standing or special committee to perform the function, the committee so formed or designated shall act pursuant to the authority delegated to it. The following guidelines shall apply to all committees:

12.1-1 Chair. Each Medical Staff committee shall be chaired by such Staff member as is designated by these Bylaws or, in the absence of such designation, as is appointed by the Chief of Staff. Each joint committee of the Medical Staff and Hospital shall be chaired by such individual as is designated in these Bylaws or, in the absence of such designation, as is appointed by concurrence of the Chief of Staff and President.

12.1-2 Meetings. Except as specifically required by these Bylaws, committees of the Medical Staff will meet at least quarterly unless otherwise agreed or required by the MEC. Except as specifically required by these Bylaws, joint committees of the Medical Staff and Hospital will meet at least twice a year unless otherwise agreed or required by the MEC and the President.

12.1-3 Attendance. Each Practitioner with Privileges that require attendance at Medical Staff meetings must comply with Section 13.7 of the Medical Staff Bylaws. An attendance record shall be kept at all regular and special meetings and department and division meetings of the Medical Staff. If a Practitioner wishes to be excused from a meeting, he or she should submit a request with the reason to the Chief of Staff or to the chief or chair of the applicable department or division, who will decide the validity of the request.

12.2 MEDICAL EXECUTIVE COMMITTEE

12.2-1 Composition. The Medical Executive Committee shall consist of the following:

(1) Chief of Staff,
(2) Vice Chief of Staff,
(3) Medical Staff Secretary-Treasurer,
(4) Chief of Medicine,
(5) Chief of Surgery,
(6) Chief of Obstetrics/Gynecology,
(7) Chief of Pediatrics,
(8) Chief of Family Medicine,
(9) Chief of Anesthesiology,
(10) Chief of Pathology,
(11) Chief of Radiology,
(12) Chief of Emergency Medicine,
(13) Chief of Orthopaedic Surgery,
(14) Immediate past Chief of Staff or other physician responsible for the Credentials function,
(15) Physician who chairs the Medical Staff delegation for the Medical Record function; and
(16) One physician at large who is appointed by the Chief of Staff.

The Chief of Staff shall be Chairman of the Medical Executive Committee and shall preside at meetings. The President, Chief Nurse Executive, and Chief

Operating Officer or Chief Medical Officer, as determined by the President, shall be nonvoting ex officio members of the MEC. The President shall be invited to attend all meetings of the MEC and may personally attend the entire meeting if desired. Other than members who are officers or chiefs of a department, the Chief of Staff may remove any appointed member to the MEC with the approval of the MEC.

12.2-2 Duties. The Medical Executive Committee is delegated the primary authority over activities related to functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed by removing members from the MEC or by amending these Bylaws. The committee shall:

A. receive and act upon reports and recommendations from the departments, committees and officers of the Staff concerning patient care and safety and other quality maintenance activities and oversee the discharge of all delegated administrative committee responsibilities;

B. coordinate the activities of and policies adopted by the Staff, departments and committees, including, without limitation, when the rulemaking actions of a department or committee alter, constrain, restrict or otherwise impact existing patient care and safety standards or existing practice patterns. Notice of such action, as approved by the Medical Executive Committee, shall be disseminated to all members of the Medical Staff;

C. review information referred by the Credentialing Committee regarding the performance and clinical competence of the Staff members and other Practitioners with Clinical Privileges;

D. recommend to the Board all matters relating to Medical Staff structure, the process used to review credentials and to delineate individual Clinical Privileges, appointments, reappointments, Staff category, department and service assignments, Clinical Privileges, specified services, and corrective action;

E. account to the Board and to the Staff for the overall quality and efficiency of care rendered to patients in the Hospital;

F. initiate and pursue collegial intervention and corrective action, when warranted;

G. make recommendations about administrative and Hospital management matters, including the necessity of entering into an exclusive contract for particular physician services;

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 the establishment of Hospital goals and the implementation of programs to meet Hospital goals and community needs;

J. represent and act on behalf of the Staff, subject to such limitations as may be imposed by these Bylaws;

K. consult with the administration regarding quality-related aspects of contracts for patient care services provided through entities outside the Hospital and about the use of telemedicine;

L. oversee all Medical Staff committees and functions; and

M. act on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings).

12.2-3 Meetings. The Medical Executive Committee shall meet at least once a month and will maintain a permanent record of its proceedings and actions.

12.3 STAFF FUNCTIONS

Provision shall be made by the Medical Executive Committee, either through assignment to departments or to Staff committees, for the effective performance of (i) the Staff functions specified in this Section and described in Section 12.4, (ii) all other Staff functions required by these Bylaws, and (iii) such other Staff functions as the Medical Executive Committee or the Board shall reasonably require. The Medical Executive Committee, in cooperation with the Hospital administration, shall:

A. Coordinate and review credentials investigations and recommendations regarding Staff membership and grants of Clinical Privileges;

B. Coordinate and provide a forum for discussion of Hospital and Medical Staff policy, practice and planning;

C. Require that patient medical and related records are accurate, complete, timely and clinically pertinent;

D. Coordinate and review the conduct of utilization review activities;

E. Develop and maintain surveillance over drug and antibiotic utilization policies and practices;

F. Investigate, monitor and direct appropriate actions affecting patient safety;

G. Monitor and evaluate care provided in, and develop clinical policy for, special care areas, such as intensive and coronary care units; patient support services, such as respiratory therapy, physical medicine, rehabilitation and anesthesia; and emergency, outpatient, and other ambulatory care services;

H. Coordinate and review patient care monitoring activities, including quality assurance, nutrition review, surgical case review, drug utilization review, blood utilization review, and evaluation of high volume/high risk diagnoses and procedures;

I. Plan 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;

J. Provide continuing education responsive to evaluation findings, new developments, and supervise the Hospital's professional library services;

K. Monitor a functionally safe use of radiation;

L. Coordinate the care provided by Practitioners with the care provided by Patient Care and with the activities of other Hospital care and administrative services; and

M. Direct Staff organizational activities, including Staff Bylaws review and revision, Staff officer and committee nominations, liaison with the Board and Hospital Administration, and review and maintenance of Hospital accreditation.

12.4 DESCRIPTION OF FUNCTIONS

12.4-1 Credentials Function. The Credentials Function shall be performed by a committee consisting of the immediate past Chief of Staff, who will serve as chair, and one (1) member from each of the Departments of Surgery, Medicine, Anesthesiology, Obstetrics and Gynecology, Pediatrics, and Family Medicine, each of whom shall be appointed by the respective Department Chief. Other Staff members may be appointed by the Chief of Staff to serve as members at large of the Committee. Notwithstanding the requirements of Section 13.5 of these Bylaws, meetings of the Credentials Committee shall be open only to members of the Committee, the Chief of Staff, the President or his/her designee, or Practitioners, Hospital staff or other persons whom the chair has specifically authorized to be present. The Credentials Committee, which will be responsible for exercising oversight, coordination and review of credentials investigations and recommendations, shall:

A. review and evaluate the qualifications of each Practitioner who has made application for initial appointment, reappointment, or modification of appointment and for Clinical Privileges and maintain the Staff Credentials File;

B. review and evaluate the qualifications of each Recognized Medical Affiliate applying to perform specified services, unless a separate credentialing body has been created and authorized by the Medical Staff and Board to perform this function in accordance with Article V of these Bylaws;

C. submit reports to the Medical Executive Committee on the qualifications of each applicant for Staff membership or particular Clinical Privileges and of each Recognized Medical Affiliate for specified services, if applicable. Such reports shall include recommendations with respect to appointment, Staff category, department affiliation, Clinical Privileges or specified services, and special conditions, if any;

D. investigate, review, and report on matters, including the clinical or ethical conduct of any Practitioner, assigned or referred by the Chief of Staff, the Medical Executive Committee, or the Board;

E. submit regular reports to the Medical Executive Committee on the status of pending applications, including reasons for any delay in processing an application or request; and

F. forward all findings, deliberations, reports and minutes concerning the health care provided any patient by a Practitioner, or relevant to professional conduct, performance, or competence of a Practitioner, to the Medical Executive Committee.

12.4-2 Practitioners' Health Function. The Practitioners' Health Function shall be performed by a joint committee consisting of the immediate past Chief of Staff, the Chief of the Department of Medicine or other designee of the Chief of Staff, and the Chief Medical Officer or other designee of the President. The committee also will include the chief of the department of a Practitioner whose conduct and health are under review at any time. The immediate past Chief of Staff will chair the Practitioners' Health Committee. The duties of the Committee are to:

A. Assume overall responsibility for the supervision, investigation, and management of Practitioner health and behavioral issues, as requested by the MEC or President or as otherwise referred to the committee;

B. Review the conduct and performance of any Practitioner who is referred to the committee to determine whether he/she may require and may benefit

from treatment, rehabilitation, or other assistance to retain or regain optimal professional functioning;

C. Seek the cooperation of Practitioners in the diagnosis, treatment, and rehabilitation of potentially impairing conditions and monitor their progress;

D. Consistent with the protection of patients, facilitate the diagnosis, treatment and rehabilitation of Practitioners who are found to have potentially impairing conditions which may warrant such intervention;

E. Develop and communicate a process whereby concerns involving particular Practitioners may be referred to the committee, including a self-referral process;

F. Maintain the confidentiality of Practitioners who are referred or who refer themselves to the committee, except as limited by law or ethical obligations or if the safety of patients would be jeopardized;

G. Report to the Medical Executive Committee, for collegial intervention or corrective action, instances in which there is reason to believe that a Practitioner may be unable to safely perform the Privileges he/she holds and efforts to diagnose, treat or otherwise rehabilitate the Practitioner either are unwarranted or have been unsuccessful; and

H. Arrange educational programs for the Medical Staff concerning Practitioner health issues, including the prevention of physical, psychiatric, and emotional illnesses.

12.4-3 Continuous Quality Improvement Function. The CQI Function shall be performed by a committee which includes the Vice Chief of Staff, the Vice Chiefs of each of the Departments of Surgery, Orthopaedic Surgery, Internal Medicine, Obstetrics and Gynecology, Emergency Medicine, and Family Medicine or Pediatrics, and the chair of the Medical Staff delegation to each of the Surgical Case Review Committee, the Pharmacy and Therapeutics Committee, and the Medical Records Committee. Hospital personnel who will be ex officio members of the CQI Committee shall include the President, the Chief Medical Officer, the Infection Control Coordinator, the Director of risk management, and a representative from patient care. The Vice Chief of Staff shall chair the CQI Committee. The goals, objectives and duties of the CQI Committee shall be to coordinate and review departmental and Staff-wide patient care. The CQI Committee's specific functions, which will be subject to the concurrence of the MEC and will be carried out in cooperation with the Hospital administration, may include any of the following:

A. adopt, subject to the approval of the Medical Executive Committee specific programs and procedures for reviewing, evaluating, and maintaining the quality and efficiency of patient care and safety within the Hospital; including establishing and measuring objective criteria; analyzing practice variations from criteria by peers; assessing the efficiency of clinical practice patterns, undertaking and following up on appropriate action to correct identified problems; and reporting the findings and results of monitoring activity to the Medical Staff and the Board;

B. using evidenced-based criteria and other professionally accepted methods for assessing performance, regularly review and respond to matters affecting the quality and efficiency of patient care provided in the Hospital and provide for the education of patients and families and the coordination of care between and among Practitioners and Hospital personnel;

C. coordinate the findings and results of Staff monitoring procedures; Hospital utilization review activities; continuing medical education activities; medical record completeness, timeliness, and clinical pertinence; and other Staff activities designed to monitor patient care practices;

D. submit reports to the Medical Executive Committee, as requested, on the quality and efficiency of medical care in the Hospital and on department, committee, and Staff patient care, utilization review, and related quality maintenance and monitoring activities, including the performance of specific Practitioners;

E. assist in the development of criteria for the appointment and reappointment of Medical Staff members, as requested by the MEC; and

F. forward all findings, deliberations, reports, and minutes concerning the health care provided any patient by a Practitioner, or relevant to professional conduct, performance, or competence of a Practitioner, to the Medical Executive Committee.

12.4-4 Sentinel Event Review Function. The Sentinel Event Review Function required by The Joint Commission (TJC) shall be performed by a committee consisting of members of the Medical Staff and Hospital administration as established by Hospital policy. The Sentinel Event Review Committee shall review and investigate potential sentinel events, determine when the Hospital should conduct a root cause analysis of a particular event, and provide recommendations for process improvements based on the results and findings of these investigations.

12.4-5 Cancer Function. The Cancer Function shall be performed by a committee consisting of not less than six (6) representatives of the Medical Staff involved in

the care of cancer patients, including Staff members from medical oncology, surgery, pathology, radiation oncology radiology and palliative care. The committee may also include Practitioners representing the primary cancer sites, being breast, prostate, colon/rectal, lung, and gynecology. The committee will include representatives of the Hospital from patient care, social services, rehabilitation services, and the Cancer Registry. The Cancer Committee will be chaired by a member of the Medical Staff. The duties of coordinating, educating, and monitoring treatment of cancer patients are to:

A. evaluate and monitor the entire spectrum of care for cancer patients admitted to the Hospital which includes availability of consultative services in all specialties and support services for patients and their families;

B. promote a coordinated, multi-disciplinary approach to patient management and provide lifetime follow-up through the Cancer Registry and patient care evaluations;

C. develop and evaluate goals for clinical, educational and programmatic activities relating to the diagnosis and treatment of cancer and insure that such programs are available to members of the Medical Staff and Hospital staff;

D. supervise the maintenance of the Cancer Registry for quality control of abstracting, staging and reporting cancer cases;

E. promote clinical research and monitor quality management and improvement in cancer treatment through studies that focus on quality of care, access to care, and clinical outcomes;

F. appoint one member of the committee to serve as the Hospital's representative to the Cancer Liaison Program of the Commission on Cancer;

G. prepare reports as required by accrediting bodies, the MEC, or the Hospital administration; and

H. forward all findings, deliberations, reports, and minutes concerning the health care provided any patient by a Practitioner, or relevant to professional conduct, performance, or competence of a Practitioner, to the Medical Executive Committee.

12.4-6 Cardiopulmonary Care Function. The Cardiopulmonary Care Function shall be performed by a committee consisting of at least three (3) members of the Medical Staff, including one (1) representative from the Department of Surgery, one (1) representative from the Department of Anesthesia, and one (1) representative

from either the Department of Medicine, the Department of Family Medicine, or the Department of Pediatrics. The Committee shall include one (1) or more representatives of the Hospital administration and may be chaired by either a representative of the Hospital or of the Medical Staff. The duties of the Committee are to:

A. monitor and make recommendations regarding the provision of care to cardiopulmonary patients; and

B. formulate and maintain policies which assure delivery of quality care in the areas of coronary care, respiratory therapy, and cardiopulmonary resuscitation.

12.4-7 Continuing Education Function. The Continuing Education Function will be performed by a committee consisting of at least two (2) members of the Medical Staff who shall oversee the continuing education programs and materials that are available to the Medical Staff. The Committee shall:

A. evaluate the effectiveness of the educational programs implemented;

B. evaluate and make recommendations regarding the Hospital's and Medical Staff's needs for professional library services;

C. act upon recommendations for continuing education from the Medical Executive Committee, the departments, or other committees of the Medical Staff;

D. maintain a permanent record of education activities and submit reports to the Medical Executive Committee concerning such activities, as requested; and

E. organize programs for general Staff meetings and department meetings, as requested.

12.4-8 Emergency Management/Disaster Planning Function. The Emergency Management and Disaster Planning Function shall be performed by a committee that includes at least two (2) representatives of the Medical Staff, one of whom shall be a member of the Department of Emergency Medicine. This Committee also shall include at least two (2) representatives of the Hospital from the administration and patient care. The function of the Emergency Management Committee shall be to provide appropriate response to and the protection and care of Hospital patients and others at the time of internal and external disasters. The duties of the Committee are to:

A. develop and periodically review, in cooperation with the Hospital administration, a written plan designed to safeguard patients and receive casualties in the event of disasters; and

B. assure that such plan is coordinated with the inpatient and outpatient services of the Hospital, that it effectively relates to other available resources in the community and coordinates the Hospital's role with other agencies in the Hospital's service area, and that the plan is rehearsed by all key personnel at least twice a year.

12.4-9 Ethics Function. The Ethics Function will be performed by a core group consisting of at least two (2) representatives of the Medical Staff from different areas of clinical practice and such Hospital staff and other individuals as are determined to be appropriate by the Ethics Committee. Representatives shall serve staggered two (2) year terms. The chair of the Ethics Committee may be a representative either of the Hospital or of the Medical Staff. The duties of the Ethics Committee shall be to:

A. serve as a resource for considering issues within the Hospital that raise significant ethical concerns;

B. provide consultation on specific cases when requested;

C. assist in developing policies pertaining to medical ethics and refer them to the MEC for review and recommendations; and

D. educate the Medical Staff and Hospital personnel about matters that pertain to organizational ethics and medical ethics.

12.4-10 Infection Control Function. The Infection Control Function shall be performed by a committee the membership of which includes a Medical Staff representative from each of the Departments of Medicine, Surgery, Obstetrics and Gynecology, and Pediatrics, one of whom shall chair the Committee. In addition, representatives of the Hospital, including one (1) each from patient care and the Pathology Department, shall participate in the discharge of this function. The duties of preventing, investigating and controlling Hospital-acquired infections are to:

A. maintain surveillance of Hospital infection potentials and identify and analyze the incidence and cause of infections;

B. develop and implement a preventive and corrective program designed to minimize infections;

C. review infection control practices in all areas of the Hospital as requested by the Medical Executive Committee;

D. make recommendations to the Hospital administration and MEC relating to infection control concerns raised by the Chief of Staff, the Medical Executive Committee, the departments, or other Staff and Hospital committees;

E. recommend appropriate control measures or institute any reasonable study when a situation appears to present a health risk to patients or Hospital personnel;

F. maintain a permanent record of all activities relating to infection control and submit periodic reports thereon to the Medical Executive Committee and to the President; and

G. forward all findings, deliberations, reports, and minutes concerning the health care provided any patient by a Practitioner, or relevant to professional conduct, performance, or competence of a Practitioner, to the Medical Executive Committee.

12.4-11 Medical Record Function. The Medical Record Function shall be performed by a committee consisting of representatives from the Departments of Surgery, Medicine, Family Medicine, Pediatrics, and Obstetrics and Gynecology. The Medical Record Committee will include representatives from the Hospital from health information management/medical records, patient care, and risk management. The Medical Record Committee will be chaired by a member of the Medical Staff. The duties of maintaining patient medical records which are accurate, complete, timely, and clinically pertinent are to:

A. review medical records to determine whether they properly describe the diagnosis, condition, and progress of the patient, the therapy provided, and results thereof, and identify responsibility for all actions taken; are sufficiently complete so as to facilitate continuity of care and communications between those providing patient care services; meet the standards of the Staff and The Joint Commission; and are adequate, in form and content, to permit proper patient care monitoring and other quality maintenance activities;

B. act upon recommendations from the Medical Executive Committee, clinical departments, and other committees responsible for quality assurance and other quality maintenance and monitoring functions;

C. provide liaison with the Hospital administration and the medical records professionals in the employ of the Hospital on matters relating to medical records practices;

D. maintain a permanent record of all actions taken and submit reports and recommendations to the Medical Executive Committee concerning medical records practices in the Hospital, as requested;

E. approve, as appropriate, inclusion of Medical Staff specific forms in the permanent medical record, and review and approve the Hospital's Abbreviation List annually; and

F. forward all findings, deliberations, reports, and minutes concerning the health care provided any patient by a Practitioner, or relevant to professional conduct, performance, or competence of a Practitioner, to the Medical Executive Committee.

12.4-12 Nutrition Function. The Nutrition Function shall be performed by a committee including at least two (2) members of the Medical Staff, one (1) of whom shall serve as chair, and members of the Hospital including the Director of Nutrition and Food Service and such other representatives of dietary service and patient care as are appointed by the Hospital administration. The duties of the Nutrition Committee shall be to:

A. encourage communication between and among the Medical Staff, Department of Nutrition and Food Service, and representatives of patient care regarding patients' dietary needs;

B. update and approve the diet manual which is used as a guide to interpretation of modified diets;

C. report to the Medical Staff and Hospital Staff regarding developments in the science of nutrition; and

D. recommend policies concerning the nutritional care of patients.

12.4-13 Pharmacy and Therapeutics Function. The Pharmacy and Therapeutics Function shall be performed by a committee the membership of which includes at least two (2) members of the Medical Staff, one of whom shall chair the committee. The Pharmacy and Therapeutics Committee also shall include at least two (2) representatives of the Hospital, including one (1) each from the Pharmacy Department and patient care. The duties of developing and maintaining surveillance over drug and antibiotic utilization policies and practices are to:

A. develop and review periodically a drug list for use in the Hospital and evaluate clinical data concerning new drugs or preparations for use in the Hospital;

B. make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

C. maintain a permanent record of all activities relating to the pharmacy and therapeutics function and submit periodic reports and recommendations to the Medical Executive Committee, as requested, concerning drug utilization policies and practices in the Hospital;

D. perform such other duties as are assigned by the Chief of Staff or the Medical Executive Committee; and

E. forward all findings, deliberations, reports, and minutes concerning the health care provided any patient by a Practitioner, or relevant to professional conduct, performance, or competence of a Practitioner, to the Medical Executive Committee.

12.4-14 Rehabilitation Function. The Rehabilitation Function shall be performed by a committee consisting of at least two (2) members of the Medical Staff, including one (1) from the Department of Surgery and one (1) from the Department of Medicine. One of the Medical Staff members shall serve as the chair. The Rehabilitation Committee also shall consist of Hospital representatives, including the Director of Rehabilitative Services, a representative of patient care, and such other personnel as are appointed by the Hospital administration. The duties of the Rehabilitation Committee are to review and coordinate patient rehabilitation services and maintain policies which will assure delivery of high quality care in the area of physical medicine and rehabilitation.

12.4-15 Safety Function. The Safety Function shall be performed by at least two (2) members of the Medical Staff and such Hospital staff as are appointed by the Hospital administration. A representative of either the Medical Staff or the Hospital may chair the committee. The duties of the Safety Committee are to:

A. develop, implement and monitor a comprehensive Hospital-wide safety program containing requirements relating to Hospital staffing, equipment, operation and maintenance and designed to produce safe procedures and practices and to eliminate or reduce, to the extent feasible, hazards to patients, Hospital Staff and visitors;

B. develop written policies and procedures designed to enhance safety within the Hospital and on Hospital grounds;

C. coordinate and develop Medical Staff department safety rules and practices;

D. review and make recommendations pertaining to procedures for investigating, evaluating, documenting, and taking action regarding incidents that involve Hospital and patient safety;

E. monitor local, state, and federal safety regulations and ordinances and the application of these requirements to the Hospital;

F. establish methods for measuring the results of safety programs and procedures and for reviewing pertinent records and reports to determine safety program effectiveness; and

G. conduct and oversee a periodic hazard surveillance program at specifically determined intervals.

12.4-16 Surgery Administration Function. The Surgery Administration Function shall be performed by a committee consisting of the chiefs of each of the Departments of Surgery, Orthopaedic Surgery, Obstetrics and Gynecology, and Anesthesiology or their designees, one (1) other representative of the Department of Anesthesiology, who shall be designated by the Chief of the Department of Anesthesiology and approved by the MEC, one (1) other representative of the Department of Orthopaedic Surgery, who shall be designated by the Chief of the Department of Orthopaedic Surgery and approved by the MEC, and four (4) other representatives of the Department of Surgery, who shall be designated by the Chief of the Department of Surgery and approved by the MEC. In making appointments from the Department of Surgery, consideration and preference will be given to appointing Practitioners from different practice groups, specialties and areas of practice. The committee also shall include, as ex officio members, the Chief Operating Officer and the Director of the Department of Surgery. The functions of this committee are to:

A. review surgery performance data; and

B. make recommendations to the MEC and the Hospital administration regarding the scheduling of inpatient and outpatient surgical procedures.

12.5 REPRESENTATION ON INTERDISCIPLINARY HOSPITAL MANAGEMENT COMMITTEES

Staff functions and responsibilities relating to Hospital operations, communication and liaison with the Board and the Hospital administration, Hospital accreditation, and disaster planning shall be discharged by the appointment of Medical Staff members to such Hospital management committees as are established to perform those functions. One (1) of the Medical Staff representatives to each such committee shall be designated by the Chief of Staff to serve as the chairman of the Medical Staff delegation to that committee. Appointments of Medical Staff members to any Hospital management committees shall be made, and such committees shall operate in accordance with the Hospital Corporate Bylaws, the written policies of the Hospital and the Bylaws and Rules and Regulations of the Medical Staff. Hospital management committees shall be those committees, other than the committees of the Medical Staff that are identified in Section 12.6 below, as are set forth in these Bylaws and as may be created from time to time. Hospital management

committees shall meet with such frequency as is indicated in Section 12.1-2 of these Bylaws.

12.6 COMMITTEES OF THE MEDICAL STAFF

12.6-1 Composition and Appointment. The standing committees of the Medical Staff shall be the Medical Executive Committee, the Nominating Committee, the Continuous Quality Improvement Committee, the Credentials Committee, the Continuing Medical Education Committee, the Practitioners' Health Committee, and the Surgery Administration Committee. These committees shall consist of such members as are identified in these Bylaws. The Chief of Staff or designee shall serve as an ex officio member of all committees of which he/she is not a voting member, unless otherwise expressly provided in these Bylaws. Representatives from the Hospital administration and management and nursing staffs may attend Medical Staff committee meetings as necessary and appropriate to discharge Medical Staff functions, except as otherwise provided in these Bylaws. These individuals shall not be construed to be members of such committees, nor shall they be permitted to vote on any matters considered or acted upon by such standing committees of the Medical Staff.

12.6-2 Term and Prior Removal. Unless otherwise specifically provided, membership of a Medical Staff member on a committee shall continue until his successor is elected or appointed. A Medical Staff committee member, other than one serving in an ex officio capacity, may be removed by recommendation of the committee chair and a majority vote of the Medical Executive Committee. The Practitioner will be given at least ten (10) days' written notice and will be allowed to address the MEC before the MEC votes on removing the Practitioner from the committee.

12.6-3 Vacancies. Unless otherwise specifically provided, vacancies on any Medical Staff committee shall be filled in the same manner in which original appointments to such committee are made.

12.6-4 Meetings. Except as otherwise provided herein, a Staff committee responsible for the performance of one (1) or more of the Staff functions established by these Bylaws shall meet as often as is necessary to discharge its assigned duties, but no less often than quarterly, as set forth in Section 12.1 of these Bylaws.

ARTICLE XIII. MEETINGS

13.1 GENERAL STAFF MEETINGS

13.1-1 Regular Meetings. Regular meetings of the Medical Staff shall be held four (4) times each year, at least once each quarter. The annual meeting shall be held in the fourth (4th) quarter. Notice of quarterly meetings shall be provided as set forth in Section 13.3. The order of business at a quarterly meeting of the Medical Staff shall be determined by the Chief of Staff.

13.1-2 Special Meetings. Special meetings of the Medical Staff may be called at any time by the Chief of Staff on his/her own determination, by majority vote of the Medical Executive Committee, or by the Chief of Staff upon written request signed by ten (10) members of the Active or Senior Active Medical Staff. Notice of a special meeting shall be provided as set forth in Section 13.3. No business shall be transacted at any special meeting except that stated in the meeting notice.

13.1-3 Procedures. Procedure will be governed by Sturgis Rules of Order, except as otherwise stated in the Bylaws, Rules and Regulations.

13.1-4 Attendance. Members of the Medical Staff and the President of the Hospital shall be entitled to attend all Regular and Special meetings of the Medical Staff. Other Hospital staff and Guests may attend these meetings at the discretion of the Chief of Staff and the MEC. The Chief of Staff will have the authority to close a meeting or a portion of a meeting and to exclude anyone other than the President or a member of the Medical Staff.

13.2 COMMITTEE AND DEPARTMENT MEETINGS

13.2-1 Regular Meetings. Committees and departments shall provide notice of regular meetings either in accordance with Section 13.3 or by annual resolution, providing the time and location for regular meetings, in which case no other notice shall be required. Except as otherwise provided in these Bylaws, committees, departments and divisions shall hold regular meetings at least quarterly to carry out the responsibilities of that committee, department or division.

13.2-2 Special Meetings. A special meeting of any committee, department or division may be called by, or at the request of, the chairman or chief thereof, by the Medical Executive Committee, by the Chief of the Medical Staff, or by one-third (1/3) of the Active or Senior Active Staff members of that committee, department or division. Notice of a special meeting shall be provided as set forth in Section 13.3. No business shall be transacted at any special meeting except that stated in the meeting notice.

13.3 NOTICE OF MEETINGS

Written notice stating the place, day and time of any regular or special meeting of the Medical Staff, or of any regular or special committee, department or division not held pursuant to resolution, shall be delivered either personally or by mail to each Practitioner or other person who is entitled to be present at the meeting. For Medical Staff meetings, written notice shall be given not less than seven (7) days before the date of such meeting unless otherwise specifically provided in these Bylaws. For department, division and committee meetings, written notice shall be given not less than three (3) days before the date of such meeting. If mailed, the notice of the meeting shall be deemed delivered when

deposited, postage prepaid, in the United States mail addressed to each person entitled to such notice at his/her address as it appears on the records of the Hospital. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 QUORUM

13.4-1 Regular Medical Staff Meetings. A quorum for any regular or special meeting of the Medical Staff, except as otherwise provided in Section 16.7, shall consist of the number of voting members of the Medical Staff in attendance at that meeting.

13.4-2 Department and Committee Meetings. For meetings of the MEC, Credentials Committee, and CQI, a quorum shall consist of fifty percent (50%) of the voting members of each body. For the meetings of other committees, departments and divisions, a quorum shall consist of the number of members of that committee, department, or division in attendance at the meeting. Notwithstanding the foregoing, the Credentials Committee may submit a favorable recommendation to the MEC regarding the application for Staff membership and Privileges of a Practitioner even if fewer than 50% of the voting members of the Committee were present to review the Practitioner's application.

13.5 ATTENDANCE AND MANNER OF ACTION

13.5-1 Attendance.

A. Except as provided in these Bylaws or by Hospital policy, meetings of departments, divisions and committees will be open to all members of that department, division or committee. Other members of the Medical Staff and Hospital staff or other Guests may attend these meetings at the discretion of the chief or chair of that department, division, or committee. The chief or chair of a department, division, or committee will have the authority to close any meeting or portion of a meeting and to exclude anyone other than the Chief of Staff or designee, the President or designee, or a member of that department, division, or committee. Notwithstanding the forgoing, if a department, division or committee reviews the professional practices or performance of a Practitioner at any time, then the chair will have the authority to exclude that individual from the meeting or portion of a meeting in which the Practitioner's performance is being considered.

B. If a department, division, or committee reviews the clinical practices or performance of a specific Practitioner at any time, then such meeting or portion of a meeting will be limited to Practitioners who are members of the department or division, the Chief of Staff or designee, the President or designee, and such other persons as are invited by the department chief, division chair, or committee chair to be present. The Practitioner who is

the subject of such review may be excluded from the meeting, at the determination of the chief or chair.

13.5-2 Quorum. Except as otherwise specified in these Bylaws or by Hospital policy, the action of a majority of a quorum at a department or committee meeting shall be the action of the group.

13.6 MINUTES

Minutes of all meetings of the Medical Staff, and of committees, departments and divisions of the Medical Staff, shall be prepared by the Secretary or designee of that body and shall include a record of attendance and a record of action. Minutes shall be signed by the presiding officer and shall be forwarded to the Medical Executive Committee. A permanent file of the minutes, not concerning the health care provided any patient or related to professional conduct, performance or competence of a Practitioner, shall be maintained and made available to Practitioners on the Medical Staff on request, except to the extent that the minutes contain confidential information that is protected by the peer review privilege and access is not otherwise allowed by applicable provisions of the Fair Hearing Plan appended hereto.

13.7 ATTENDANCE REQUIREMENTS

13.7-1 Regular Attendance. Each member of a Staff category authorized and required to attend meetings is expected to attend at least one (1) quarterly meeting of the Medical Staff and at least one (1) department meeting per year.

13.7-2 Special Appearance. A Practitioner whose clinical course of treatment or professional conduct is scheduled for discussion at a regular or special department, division or committee meeting shall be so notified. The chairman or chief of the committee, department or division shall give the Practitioner at least three (3) days advance written notice of the time and place of the meeting. Whenever an apparent or suspected deviation from standard clinical practice is involved, the notice shall include a statement of the issue involved and that the Practitioner's appearance is mandatory. The notice shall also advise the Practitioner that his/her failure to appear may result in action against the Practitioner's Privileges. If, in the judgment of the Medical Executive Committee, the circumstances warrant this action, the failure of a Practitioner to appear, without good cause, at a meeting with respect to which he/she was given special notice may result in an automatic relinquishment of all or a portion of the Practitioner's Clinical Privileges. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee or the Board or through corrective action, if necessary.

ARTICLE XIV. CONFIDENTIALITY AND IMMUNITY

14.1 AUTHORIZATIONS AND CONDITIONS

By applying for, or exercising, Clinical Privileges, or providing specified patient care services within the Hospital, a Practitioner:

A. authorizes representatives of the Hospital, and the Medical Staff to solicit, provide and act upon information bearing on his/her professional performance, conduct, and qualifications;

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

C. acknowledges that the provisions of this ARTICLE are express conditions to his/her application for, or acceptance of, Staff membership, or his/her exercise of Clinical Privileges or provision of specified patient services at the Hospital.

14.2 CONFIDENTIALITY OF INFORMATION

Information about the professional practices or conduct of specific Practitioners that is submitted, collected or prepared by any representative of the Hospital or any other health care facility or organization or Medical Staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disclosed to anyone other than authorized representatives of the Medical Staff or the Hospital administration nor used in any way except as provided by law or in these Bylaws. 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 medical record or general Hospital records.

14.3 IMMUNITY FROM LIABILITY

14.3-1 For Action Taken. No representative of the Hospital or Medical Staff shall be liable in any judicial or other proceedings or damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative, if such representative acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts. Regardless of any provisions of state law, truth shall be an absolute defense in all circumstances.

14.3-2 For Providing Information. No representative of the Hospital or Medical Staff and no third party shall be liable in any judicial or other proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff or to any other hospital, organization of health professionals, or other health-related organization, concerning a Practitioner or Affiliate who is or has been an applicant to or member of the Staff or who did or does exercise Clinical Privileges or provide specified services at this Hospital provided that such representative or third party acts in good faith and without malice.

14.4 ACTIVITIES AND INFORMATION COVERED

14.4-1 Activities. The confidentiality and immunity provided in this ARTICLE shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

A. applications for appointment, Clinical Privileges, or specified services;

B. periodic reappraisals for reappointment, Clinical Privileges, or specified services;

C. corrective action;

D. hearings and appellate reviews;

E. patient care monitoring;

F. quality assurance reviews;

G. utilization reviews;

H. peer review activities pursuant to Section 537.035, RSMo.(1985); 42 U.S.C. §§ 11111-11112 (1986); and

I. other hospital, department or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

14.4-2 Information. The acts, communications, reports, recommendations, disclosures, and other information referred to in this ARTICLE may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, ability to perform the Privileges requested, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

14.5 RELEASES

Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with this ARTICLE, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of Missouri. Execution of such releases shall not be nor be deemed to be a prerequisite to the effectiveness of this ARTICLE.

14.6 CUMULATIVE EFFECT

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

ARTICLE XV. GENERAL PROVISIONS

15.1 CONFLICTS OF INTEREST

All Medical Staff officers, department chiefs, division and committee chairs, appointees, candidates for office, and other Medical Staff leaders discharging responsibilities pursuant to these Bylaws have a duty of loyalty and fidelity to the Medical Staff and to the Hospital to promote the interests of both fairly, honestly and economically, in the exercise of their best judgment at all times. Accordingly, it shall be the responsibility of each such officer, department chief, division and committee chair, and Medical Staff leader to disclose fully and frankly to the Medical Executive Committee, the President, and the Board any and all actual or potential conflict or duality of interest (including, but not limited to, leadership responsibility on another Medical Staff, involvement in a competing business venture, or equity interest in a major supplier or contractor with the Hospital or Medical Staff) which may exist or appear with respect to such office or responsibility or as to any matter or business which may come before the Medical Staff, department, committee or Hospital at any time. Such disclosure shall be made prior to action by such body on any such matter. This requirement of disclosure of conflicts of interest shall not prohibit any such officer or department chief or division or committee chair from responding to questions concerning the matter nor from participating in discussion, nor from voting provided such action shall have been approved by resolution of the appropriate body following disclosure of all actual or apparent conflict or duality of interests, which approval shall be entered upon the record of the meeting. All conflicts disclosures, and action taken thereon, if any, shall be recorded in the minutes of the relevant body.

15.2 PROFESSIONAL LIABILITY INSURANCE

Each Practitioner granted Clinical Privileges in the Hospital shall maintain professional liability insurance in full force and effect at all times having minimum limits of liability of not less than Five Hundred Thousand Dollars ($500,000.00) per occurrence, or such limits as otherwise mandated by law, except that dentist and podiatrist members shall

have minimum limits of liability of not less than Two Hundred Thousand Dollars ($200,000.00) per occurrence, or such limits as otherwise mandated by law. The limits of such insurance coverage, the issuing carrier(s), and expiration date of all such policies shall be included in all applications for appointment and reappointment to the Medical Staff.

15.3 STAFF DUES

Annual Staff dues shall be established as determined from time to time by the Medical Executive Committee for each category of Staff membership. The amount of the fee for processing Staff applications shall be as determined from time to time by the Medical Executive Committee which shall determine the manner of expenditure of all such funds received. Medical Staff dues shall be due January 1 each year. A Practitioner's failure to pay Medical Staff annual dues by April 1 each Medical Staff Year shall be considered a voluntary relinquishment of his/her Privileges until payment is made.

15.4 FORMS

Application forms and any other forms used in connection with Medical Staff appointments, reappointments, delineation of Clinical Privileges, corrective action, notices, recommendations, reports, and other matters shall be adopted by the MEC, subject to the approval of the President and the Board.

15.5 CONSTRUCTION OF TERMS AND HEADINGS

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

15.6 TRANSMITTAL OF REPORTS

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

15.7 HISTORY AND PHYSICAL REQUIREMENTS

A complete history and physical examination shall be completed within thirty (30) days before or twenty-four (24) hours immediately after admission or registration, and, for surgical patients, must be done prior to the procedure. The examination shall be recorded in the patient's medical record and should include the patient's medical history, major complaint(s), symptoms and preliminary diagnosis. Any history and physical performed more than thirty (30) days prior to an admission or registration must be re-completed. A history and physical that is more than thirty (30) days old may be entered into the medical record at admission or registration only for historical reference purposes and may not be

relied upon with respect to the admission or surgery/invasive procedure. If a history and physical examination has been completed within the thirty (30) day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record to satisfy this requirement; however, in these circumstances, the patient must be evaluated within twenty-four (24) hours after the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record. The update of the history and physical examination must reflect (i) any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition. A history and physical must be completed and documented in the medical record for inpatients and outpatients who are to have surgery, sedation, or other invasive procedures prior to the procedure. Invasive procedures include those in which the patient will have general anesthesia, spinal anesthesia, or regional anesthesia, and where there is major body cavity involvement. The report of the history and physical must be dated and authenticated by the Practitioner as further set out in Section B-1 of the Rules and Regulations of the Medical Staff.

ARTICLE XVI. ADOPTION AND AMENDMENT OF BYLAWS AND RULES AND REGULATIONS

16.1 MEDICAL STAFF BYLAWS

The Medical Staff shall have the responsibility and delegated authority to formulate, adopt, 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 at the professionally recognized level of quality and efficiency in the community, and of maintaining a harmony of purpose and effort with the Board and the community.

16.2 ADOPTION AND AMENDMENT OF BYLAWS

Medical Staff Bylaws may be adopted, amended, or repealed by the following actions:

16.2-1 Medical Staff. Recommendations for modifications of the Bylaws may be made upon an affirmative vote of a majority of the Medical Staff members eligible to vote at a duly called meeting of the Medical Staff provided that at least ten (10) days written notice of the proposed Bylaws modification or amendment has been given. Usually such action by the Medical Staff shall be pursuant to a recommendation of the MEC.

16.2-2 Board. The recommendations of the Medical Staff must be supported by an affirmative vote of a majority of the members of the Governing Board. If the Board does not support the recommendations in whole or part, then the Board

shall refer the matter to the MEC and the Medical Staff for further consideration and recommendations.

16.3 MEDICAL STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Medical Staff shall adopt such rules and regulations as are necessary to implement the responsibilities of the Medical Staff as set forth in these Bylaws, in accordance with the process identified in Section 16.2 above. These rules and regulations may relate to Medical Staff organizational activities or the professional practices and conduct required of Medical Staff members and Recognized Medical Affiliates. If the voting members of the Medical Staff propose to adopt a rule or regulation, or an amendment thereto, they first communicate the proposal to the MEC. If the MEC proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the Medical Staff.

16.4 PROVISIONAL AMENDMENTS TO RULES AND REGULATIONS

If there is a documented need for an immediate modification of the rules and regulations, the MEC may recommend to the Governing Board and the Board may take action on the MEC's recommendation to amend the rules and regulations on a provisional basis. This may occur without a prior recommendation by the Medical Staff but the MEC will immediately notify the Medical Staff of the amendments that have been adopted provisionally and the reason for the changes. The Medical Staff will be given an opportunity to review and comment on the amendments and, if there is disagreement about the modifications, the matter will be presented to the Medical Staff at the next duly called meeting for discussion and a vote. If a majority of the Medical Staff members present oppose the amendments in whole or part, then any further revisions of the rules and regulations that are recommended by the Medical Staff will be referred to the Board for further review and final action.

16.5 POLICIES

Subject to the approval of the MEC, each department and committee may formulate its own policies for the conduct of its affairs and the discharge of its responsibilities. These policies must be consistent with the Bylaws and Rules and Regulations of the Medical Staff and the expectations and policies of the MEC, the Hospital and the Board.

The MEC may also adopt Medical Staff policies and amendments thereto. No prior notice is required.

Additionally, Medical Staff policies and amendments thereto may be proposed by a petition signed by a majority of the voting members of the Medical Staff. Notice of any proposed amendment to a Medical Staff policy shall be provided to the MEC at least 30 days prior to being voted upon by the Medical Staff. Any such proposed amendment will be reviewed by the MEC, which may comment on the amendment before it is forwarded to the Medical Staff for a vote.

Adoption of and changes to Medical Staff policies will become effective only when approved by the Board. A copy of such policies is to be distributed or otherwise made available to Medical Staff members and others holding clinical privileges in a timely and effective manner.

16.6 INTERPRETING BYLAWS AND REGULATIONS

If and to the extent that what is stated in the Medical Staff Bylaws and in the Rules and Regulations differ, the provisions will be interpreted in such a manner as to reconcile these differences to the extent possible. In reconciling these differences, it shall be understood that the most recent modifications and additions of the Bylaws and Rules and Regulations shall take precedence of earlier versions and that specific provisions of the Bylaws will take precedence over specific provisions of the Rules and Regulations.

16.7 CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to: (a) proposed amendments to the Medical Staff Rules and Regulations; (b) a new policy proposed by the MEC; or (c) proposed amendments to an existing policy that is under the authority of the MEC, a special meeting of the Medical Staff will be called. For purposes of this Section 16.7, a quorum must be present at any such special meeting, which quorum shall consist of twenty percent (20%) of the voting members of the Medical Staff and fifty percent (50%) of the members of the MEC, including at least one (1) MEC member who is not an officer. For purposes of determining if a quorum is present, physicians may be counted toward the requirements for both Medical Staff and MEC attendance. Further, at least three (3) Medical Staff departments must be represented by non-MEC member physicians for purposes of a quorum under this Section 16.7.

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

(3) If the differences cannot be resolved at the meeting, the MEC will forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.

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

RULES AND REGULATIONS

FAIR HEARING PLAN

Definitions. The following definitions, in addition to those stated for the Medical Staff Bylaws, shall apply to this Fair Hearing Plan.

1. HEARING COMMITTEE means the committee appointed pursuant to Part B-3 of this Plan to hear a Practitioner's properly filed request for an evidentiary hearing.

2. PARTIES mean (i) Practitioner who requested the hearing or appellate review, and (ii) the body upon whose adverse action a hearing or appellate review is predicated.

3. REVIEW BODY means the group designated pursuant to Part E-4 of this Plan to hear a Practitioner's properly filed request for appellate review.

PART A. INITIATION OF HEARING

A-1 Recommendations or Actions. The following recommendations or actions shall, if deemed adverse pursuant to Part A-2, entitle the Practitioner affected thereby to a hearing:

(a) denial of initial Staff appointment;

(b) denial of reappointment;

(c) suspension of Staff membership;

(d) revocation of Staff membership;

(e) denial of requested advancement in Staff category;

(f) reduction in Staff category;

(g) limitation of admitting Prerogatives;

(h) denial of requested department affiliation;

(i) denial of requested Clinical Privileges;

(j) reduction in Clinical Privileges;

(k) suspension of Clinical Privileges;

(l) revocation of Clinical Privileges;

(m) terms of probation; and

(n) requirement of consultation.

A-2 When Deemed Adverse. A recommendation or action, listed in Part A-1, shall be deemed adverse action only when it has been:

(a) recommended by the Medical Executive Committee;

(b) taken by the Board contrary to a favorable recommendation by the Medical Executive Committee; or

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

A-3 Notice of Adverse Recommendation or Action. A Practitioner against whom adverse action has been taken, pursuant to Part A-2, shall promptly be given Special Notice of such action. Such Special Notice shall state:

(a) that an adverse action has been taken, stating the action taken;

(b) that the Practitioner has the right to request a hearing stating the required procedures and time limitations therefore;

(c) the reasons for the adverse action taken, including a concise statement of the Practitioner's alleged acts or omissions, and, as appropriate, a list by number of specific or representative patient records involved, or other reasons or subject matter forming the basis for the adverse recommendation or action; and

(d) that the Practitioner's rights at the hearing shall be governed by the Fair Hearing Plan.

A-4 Request for Hearing. A Practitioner shall have thirty (30) days following delivery of a notice pursuant to Part A-3 to file a written request for hearing. Such request shall be delivered to the President either in person or by Certified Mail.

A-5 Failure to Request a Hearing. A Practitioner who fails to request a hearing within the time and in the manner required by Part A-4 shall be deemed to have accepted and acquiesced in the adverse action and shall have no right thereafter to such hearing nor to any appellate review to which he/she might otherwise have been entitled. In such event:

(a) An adverse action by the Board shall thereupon become effective as the final decision of the Board.

(b) An adverse recommendation by the Medical Executive Committee shall thereupon become and remain effective pending the final decision of the Board.

The Board shall consider the Committee's recommendation at its next regular meeting following expiration of the period set forth in Part A-4. In its deliberations the Board shall review all the information and material considered by the Committee and may consider all other relevant information received from any source. If the Board's action changes the Medical Executive Committee's recommendation, the matter shall be submitted to a joint conference as provided in Part G-2 of this Plan. The Board's action on the matter following receipt of the joint conference recommendation shall constitute a final decision.

The President shall promptly send the Practitioner Special Notice, informing him of each action taken pursuant to this Part A-5, and shall notify the Chief of Staff of each such action.

PART B. HEARING PREREQUISITES

B-1 Notice of Time and Place for Hearing. Upon receipt of a timely request for hearing, the President shall deliver such request to the Chief of Staff or to the Chairman of the Board, depending on which recommendation or action prompted the request for hearing. The Chief of Staff or Board Chairman shall schedule and arrange a hearing. At least thirty (30) days prior to the date set for hearing, the President shall send the Practitioner Special Notice of the time, place and date of the hearing. The hearing date shall be not less than thirty (30) days nor more than sixty (60) days from the date of the notice of the hearing. Such notice shall include a statement of the place, date and time of the hearing, and a list of all witnesses, if any, expected to testify at the hearing on behalf of the party adverse to the Practitioner.

B-2 Appointment of Hearing Committee.

B-2-1 By Medical Staff. A hearing, pursuant to Part A-2(a), shall be conducted by a Hearing Committee appointed by the Chief of Staff, composed of three (3) members of the Medical Staff. One member so appointed shall be designated as chairman. Hearing Committee members shall not be in direct competition with the Practitioner seeking the hearing.

B-2-2 By Board. A hearing, pursuant to Part A-2(b) or (c), shall be conducted by a Hearing Committee appointed by the Chairman of the Board and composed of five (5) persons. At least three (3) Medical Staff members shall be included on this committee. One of the appointees shall be designated as chairman. Hearing Committee members shall not be in direct competition with the Practitioner seeking the hearing.

B-2-3 Service on Hearing Committee. A Medical Staff or Board member shall not be disqualified from serving on a Hearing Committee merely because he/she may have knowledge of the facts. All members of a Hearing Committee shall be required to consider and decide the case with good faith objectivity.

PART C. HEARING PROCEDURE

C-1 Personal Presence. The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have accepted the adverse action in the same manner and with the same consequence as provided in Part A-5.

C-2 Presiding Officer. Either the Hearing Officer, if one is appointed pursuant to Part H-1, or the Chairman of the Hearing Committee, shall be the presiding officer. The presiding officer shall maintain decorum and assure all participants in the hearing a reasonable opportunity to present relevant oral and documentary evidence. He/she shall determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the admissibility of any matter.

C-3 Representation. The Practitioner who requested the hearing may be accompanied and represented at the hearing by an attorney or any other person of the Practitioner's choice. The Medical Executive Committee, when its recommendation has prompted the hearing, shall appoint one of its members to represent it at the hearing. Representation of either party by an attorney at law shall be as provided in Part H-2.

C-4 Rights of Parties. During a hearing, each of the Parties shall have the right to:

(a) be represented by an attorney or other person of the Parties' choice;

(b) call and examine witnesses;

(c) introduce exhibits;

(d) cross-examine any witness on any matter relevant to the issues;

(e) impeach any witness;

(f) rebut any evidence;

(g) make or cause to be made a record of the hearing by a court reporter or an electronic recording unit; and

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

The Practitioner who requested the hearing may testify and may be called and examined as if under cross-examination.

C-5 Procedure and Evidence. The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of admissibility in a court of law. Each party, prior to or during

the hearing, may submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The presiding officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him and entitled to notarize documents in the state where the hearing is held.

C-6 Official Notice. In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of Missouri. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given opportunity to timely request that a matter be officially noticed and to refute any officially noticed matters by evidence. The committee shall also be entitled to consider any pertinent material contained on file at the Hospital, and all other information that can be considered, pursuant to the Medical Staff Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for Clinical Privileges.

C-7 Burden of Proof. When a hearing relates to Part A-1 (a), (h), or (I), the Practitioner who requested the hearing shall have the burden of proving by competent and substantial evidence that the adverse recommendation or action lacks credible factual basis, or that such basis or the conclusions drawn therefrom are arbitrary, capricious or unreasonable. Otherwise, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof, but the Practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or action by competent and substantial evidence that the grounds therefore lack creditable factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, capricious or unreasonable.

C-8 Record of Hearing. A record of the hearing shall be kept. The Hearing Committee shall select the method to be used for making the record, such as court reporter or electronic recording unit. A party electing an alternate method under Part C-4(g) shall bear the cost thereof.

C-9 Postponement. Requests for postponement of a hearing shall be in writing and shall be granted by the Hearing Committee only upon a showing of good cause.

C-10 Recesses and Adjournment. The Hearing Committee may recess a hearing and reconvene without further notice. Upon conclusion of the presentation of evidence, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Parties. Upon the conclusion of its deliberations, the hearing shall be declared adjourned.

PART D. HEARING COMMITTEE REPORT AND FURTHER ACTION

D-1 Hearing Committee Report. Within twenty (20) days after adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations and shall forward the same, together with the hearing record and all documentation considered by it, to the body whose adverse recommendation or action gave rise to the hearing. All findings and recommendations by the Hearing Committee shall be supported by reference to the hearing record and the documentation considered by it. A copy of the Hearing Committee Findings and Recommendations shall be forwarded concurrently to the Practitioner.

D-2 Action on Hearing Committee Report. At its next regular meeting after receipt of the report of the Hearing Committee, the Medical Executive Committee or the Board, as the case may be, shall consider the same and affirm, modify or reverse its recommendation or action in the matter, and shall transmit the result, together with the hearing record, the report of the Hearing Committee, and all documentation considered, to the President.

D-3 Notice and Effect of Result.

D-3-1 Notice. The President shall promptly give Special Notice of the result to the Practitioner, to the Chief of Staff and, if appropriate, to the Board.

D-3-2 Effect of Favorable Result.

(a) Adopted by the Board. If the Board's result, pursuant to Part D-2, is favorable to the Practitioner, such result shall become the final decision of the Board and the matter shall be closed.

(b) Adopted by the Medical Executive Committee. If the Medical Executive Committee's result, pursuant to Part D-2, is favorable to the Practitioner, the President shall promptly forward it, together with all supporting documentation, to the Board for final action. The Board shall take action thereof by adopting or rejecting the Medical Executive Committee's result in whole or in part, or by referring the matter back to the Medical Executive Committee for reconsideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The President shall promptly send the Practitioner Special Notice informing him of each action taken pursuant to this Part D-3-2(b). Favorable Board action shall become the final decision of the Board, and the matter shall be closed. If the Board's action is adverse in any of the respects listed in Part A-1, the Special Notice shall inform the Practitioner of his right to request an appellate review by the Board as provided in Part E-1 of this Plan.

D-3-3 Effect of Adverse Result. If the result of the Medical Executive Committee or of the Board, pursuant to Part D-2, continues to be adverse to the Practitioner in any of the respects set forth in Part A-1, the Special Notice required by Part D-3-1 shall inform the Practitioner of his right to request an appellate review by the Board as provided in Part E-1 of this Plan.

PART E. INITIATION AND PREREQUISITES OF APPELLATE REVIEW

E-1 Request for Appellate Review. A Practitioner shall have ten (10) days following his receipt of notice, pursuant to Part D-3-2(b) or D-3-3, to file a written request for appellate review. Such request shall be delivered to the President either in person or by Certified Mail.

E-2 Failure to Request Appellate Review. A Practitioner who fails to request an appellate review within the time and in the manner specified in Part E-1, shall be deemed to have accepted the adverse action as provided in Part A-5.

E-3 Notice of Time and Place for Appellate Review. Upon receipt of a timely request for appellate review, the President shall deliver such request to the Board. The Board shall schedule and arrange for an appellate review, which shall not be less than thirty (30) days nor more than fifty (50) days from the date of receipt of the appellate review request; provided, however, that an appellate review for a Practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than twenty (20) days from the date of the request. At least fifteen (15) days prior to the appellate review, the President shall send the Practitioner Special Notice of the time, place and date of the review. The time for the appellate review may be extended by the review body for good cause.

E-4 Review Body. The Board shall determine whether the appellate review shall be conducted by the Board as a whole, or by a review body composed of not less than three (3) members of the Board appointed by the Chairman. If a committee is appointed, one (1) of its members shall be designated chairman.

PART F. APPELLATE REVIEW PROCEDURE

F-1 Nature of Proceedings. The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, that committee's report, and all subsequent results and actions thereon. The review body shall also consider the written statements submitted, pursuant to Part F-2, and such other materials as may be presented and accepted under Parts F-4 and F-5.

F-2 Written Statements. The Practitioner seeking review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, and his reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its

preparation. The statement shall be submitted to the review body through the President at least ten (10) days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the Medical Executive Committee or by the Board, and if submitted, the President shall provide a copy thereof to the Practitioner at least seven (7) days prior to the scheduled date of the appellate review.

F-3 Presiding Officer. The chairman of the review body shall be the presiding officer. He/she shall determine the order of procedure during the review, make all required rulings and maintain decorum.

F-4 Oral Statement. The review body, in its sole and absolute discretion, may allow the Parties or their representatives to appear personally and make oral statements of their positions. Any party or representative so appearing shall answer questions put to him by any member of the review body.

F-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, shall be introduced at the appellate review only under unusual circumstances. The review body, in its sole discretion, shall determine whether such matters may be considered or accepted.

F-6 Powers. The review body shall have all powers granted to a Hearing Committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

F-7 Recesses and Adjournment. The review body may recess the review proceedings and reconvene without further notice. Upon the conclusion of oral statements, if any, the appellate review shall be closed. The review body shall thereupon conduct its deliberations outside the presence of the Parties. Upon the conclusion of deliberations, the review body shall be adjourned.

F-8 Action Taken. The review body may recommend that the Board affirm, modify or reverse the adverse result or action taken by the Medical Executive Committee or by the Board, pursuant to Part D-2 or Part D-3-2(b), or, in its discretion may refer the matter back to the Hearing Committee for further review and recommendation in accordance with its instructions. The review body shall make its recommendation to the Board as provided in this Part F-8 within thirty (30) days of its review.

F-9 Conclusion. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Part F have been completed or waived.

PART G. FINAL DECISION OF THE BOARD

G-1 Board Action. At the next regular meeting of the Board, following the conclusion of the appellate review, the Board shall render its final decision in the matter in writing and shall send notice thereof to the Practitioner by Special Notice. The Board shall also send

notice to the President, the Chief of Staff and the Medical Executive Committee. If this decision is in accord with the Medical Executive Committee's last recommendation in the matter, if any, it shall be immediately effective and final. If the Board's action changes the Medical Executive Committee's last recommendation, if any, the Board shall refer the matter to a joint conference as provided in Part G-2. The Board's action on the matter following receipt of the joint conference recommendation shall be immediately effective and final.

G-2 Joint Conference Review. Within thirty (30) days of its receipt of a matter referred to it by the Board, pursuant to the provisions of this Plan, a joint conference of equal numbers of Medical Staff and Board members shall convene to consider the matter and shall submit its recommendation to the Board. The joint conference shall be composed of a total of four (4) members selected as follows: The Chairman of the Board shall appoint two (2) Medical Staff members and the Chief of Staff shall appoint two (2) Board members.

PART H. GENERAL PROVISIONS

H-1 Hearing Officer Appointment and Duties. The use of a Hearing Officer to preside at an evidentiary hearing is optional. The use and appointment of such officer shall be determined by the Board after consultation with the Chief of Staff. A Hearing Officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/she shall act in an impartial manner as the presiding officer at the hearing. If requested by the Hearing Committee, he/she may participate in its deliberations and act as its legal advisor, but he/she shall not be entitled to vote.

H-2 Attorneys at Law. If the affected Practitioner desires to be represented by an attorney at law or any other person of the Practitioner's choice at any hearing or at any appellate review appearance pursuant to Part F-4, the written request for such hearing or appellate review must so state. If the Practitioner is so represented, the Medical Executive Committee or the Board shall be allowed representation by an attorney at law. The foregoing shall not deprive the Practitioner, the Medical Executive Committee or the Board of the right to legal counsel in connection with preparation for a hearing or an appellate review.

H-3 Consent to Adverse Action. If at any time after receipt of Special Notice of an adverse recommendation, action or result, a Practitioner fails to make a required request, or fails to make a required appearance without good cause or excuse, or otherwise fails to comply with this Fair Hearing Plan, he/she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws then if effect or under this Fair Hearing Plan, with respect to the matter involved.

H-4 Number of Reviews. Notwithstanding any other provision of the Medical Staff Bylaws, or of this Plan, no Practitioner shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review with respect to an adverse recommendation or action.

H-5 Release. By requesting a hearing or appellate review under this Fair Hearing Plan, a Practitioner agrees to be bound by the provisions of ARTICLE XIV of the Medical Staff Bylaws in all matters relating thereto.

PART I. ADOPTION AND AMENDMENT

I-1 Adoption.

I-1-1 Medical Staff. This Fair Hearing Plan shall be deemed adopted and recommended to the Board by the action of the Medical Staff adopting and recommending the Medical Staff Bylaws, of which this Plan is a part.

I-1-2 Board. This Fair Hearing Plan shall be approved and adopted when the Board, after considering the recommendation of the Medical Staff regarding the Medical Staff Bylaws of which this Plan is a part, by resolution adopts such Bylaws.

I-2 Amendment. This Fair Hearing Plan may be amended or repealed, in whole or in part, by a resolution of the Medical Executive Committee recommended to and adopted by the Board, subject always to the Bylaws of the Medical Staff and the Hospital corporation.

I-3 Medical Staff Responsibility and Board Initiative. The principles stated in the Medical Staff and Hospital Corporate Bylaws, regarding Medical Staff responsibility and authority to formulate, adopt and recommend Medical Staff Bylaws and amendments thereto and the circumstances under which the Board may resort to its own initiative in accomplishing those functions shall apply as well to the formulation, adoption and amendment of this Fair Hearing Plan.

MEDICAL STAFF RULES AND REGULATIONS

Definitions. Capitalized words and terms in these Rules and Regulations shall have the same meanings and definitions as are set forth for such words and terms in the Medical Staff Bylaws, as amended from time to time.

PART A. ADMISSION AND DISCHARGE OF PATIENTS

A-1 The Hospital shall admit patients as is deemed necessary for their care and treatment, including mental illness, except that a mentally ill patient who represents a likelihood of physical harm to himself/herself or others should be referred or appropriately transferred to another institution with suitable psychiatric care facilities and the capacity to care for the patient as soon as practicable.

A-2 A patient may be admitted to the Hospital only by a physician or oral surgeon who is a member of the Medical Staff with admitting Privileges. Practitioners without such Privileges must have a record of patient medical evaluation (history and physical) by a qualified Practitioner prior to admission as set forth in Part B of these Rules and Regulations.

A-3 The admitting Practitioner shall be responsible for the medical care and treatment of each patient admitted to the Hospital at all times, which will include responsibility for the prompt completion and accuracy of the medical record, for necessary special instructions, for giving such instructions and information as may be necessary to assure the protection of the patient or others from harm, and for transmitting reports of the condition of the patient, as necessary, to other Practitioners and Hospital staff who are caring for the patient. Whenever these responsibilities are transferred to another Practitioner, a note covering the transfer of responsibility shall be entered on the order sheet of the patient's medical record.

A-4 Except in an emergency, no patient shall be admitted to the Hospital unless a provisional diagnosis or valid reason for admission has been provided and recorded. In an emergency, such statement shall be provided and recorded as soon as practicable.

A-5 When a Practitioner determines that a patient should be admitted to the Hospital, the Practitioner shall contact the admitting department to ascertain whether there is an available bed and other capacity to provide appropriate medical care for the patient.

A-6 When the Hospital is at capacity, Practitioners who seek to admit patients on an emergent basis shall be prepared to justify to the Chief of Staff and the President of the Hospital that the emergency admission is a bona fide emergency that requires an immediate inpatient admission. The history and physical examination providing the basis for these findings must be recorded on the patient's chart as soon as practicable after admission as set forth in Part B of these Rules and Regulations.

A-7 A patient who is to be admitted through the Emergency Department who does not have a private Practitioner shall be admitted to the service of the Practitioner who is on call in the applicable department or area of medical or surgical service in accordance with applicable policies and protocols for unassigned patients.

A-8 Every patient shall be seen by his/her attending Practitioner or the Practitioner's authorized designee within twenty-four (24) hours of admission. The patient's attending Practitioner or an authorized designee shall see the patient at least daily on an ongoing basis until discharge, except in the Rehabilitation Unit where patients shall be seen by a Practitioner or authorized designee at least three (3) days a week. No patient shall be discharged without having been seen by the attending Practitioner or authorized designee within twenty-four (24) hours prior to discharge.

A-9 A member of the Medical Staff who will be unable to provide medical or surgical care for his/her inpatients at any time must designate a member of the Medical Staff with appropriate Privileges who has agreed to attend to the Practitioner's patients. In case of a Practitioner's failure to name such an alternate provider, the President of the Hospital, Chief of Staff or Chairman of the Department concerned shall have the authority to request another Practitioner with appropriate Privileges to assume responsibility for such a patient on a temporary basis.

A-10 Assuming the availability of a bed and other capacity to care for the patient, a patient may be transferred to another department or unit in the Hospital upon the request and recommendation of the attending Practitioner or his/her authorized designee.

A-11 Patients shall be discharged only on a written order of the attending Practitioner or his/her authorized designee. If a patient leaves the Hospital against the advice of the attending Practitioner, or without proper discharge orders and instructions, a notation of the incident shall be made in the patient's medical record. At the time of discharge or within the time required by Part B of these Rules and Regulations, the attending Practitioner shall see that the patient's medical record is complete, state his/her final diagnosis, and sign or authenticate the discharge orders and report.

A-12 In the event of the death of an admitted patient, the deceased shall be pronounced dead within a reasonable time by the attending Practitioner or another physician designated by the attending Practitioner. Exceptions shall be permitted in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented as being within a few hours of death in accordance with Hospital policy. The body shall not be released until documentation of the pronouncement has been made in the medical record by the attending Practitioner or his/her designee. Policies with respect to release of the deceased shall conform to local law.

A-13 In the case of the death of a patient, it shall be the responsibility of Practitioners to refer the case to the Medical Examiner if required by state law. In other circumstances, Practitioners may seek autopsies of patients. An autopsy may be performed only with the written consent of a family member or other individual who is authorized to give such

consent. All autopsies performed within the Hospital shall be performed by a Practitioner with appropriate Privileges in pathology. Provisional anatomic diagnosis shall be recorded on the medical record within twenty-four (24) hours, and the complete protocol should be made a part of the medical record within thirty (30) days, or as otherwise required by law.

A-14 With the exception of deaths described below, any death that occurs while a patient is in restraints or seclusion, within 24 hours after removal from restraints or seclusion, or within one week after being in restraints or seclusion, where it is reasonable to assume that the use of restraints or the placement in seclusion, directly or indirectly contributed to the patient's death, will be reported to the Center for Medicare & Medicaid Services ("CMS"). Reports of a patient's death must be made to CMS by telephone, facsimile or electronically as otherwise determined by CMS by the close of the next business day following knowledge of the patient's death. The date and time the notice was made to CMS must be documented in the patient's medical record.

A-15 When no seclusion has been used and the only restraint used on the patient was applied exclusively to the patient's wrists and was composed solely of soft, non-rigid, cloth-like materials, a death that occurs while a patient is in restrains or within 24 hours after removal from restrains, must be recorded in an internal log. Entries in the log must be made no later than seven days after the date of death, and must include the patient's name, date of birth, date of death, name of the practitioner responsible for the care of the patient, medical record number and primary diagnosis(es). The date and time the entries were recorded in the internal log must be documented in the patient's medical record.

PART B. MEDICAL RECORDS

B-1 Medical records must be completed and authenticated by Practitioners or their designees as authorized and required by the Bylaws and Rules and Regulations of the Medical Staff, including the requirements of this Section B. The attending Practitioner shall be responsible for the preparation of a complete and legible medical record for each patient, including a history and physical and other clinical entries that justify the admission and continued hospitalization of the patient, support the diagnosis, and describe the patient's progress and response to medications and other treatment and services. The content of the medical record shall be legible, complete, pertinent, current, dated, timed and authenticated by the Practitioner with a signature, initials, or a computer-generated code, or as otherwise authorized by federal and state law. The medical record shall include identifying data about the patient; date; chief complaint; past and present personal history; family history; history of present illness; review of symptoms; report of physical examination; admitting and other orders; plan of care; special reports such as consultations, clinical laboratory and radiologic services; admitting/provisional diagnosis; complications; infections; unfavorable reactions to drugs and anesthesia; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge and/or discharge note; follow up care; an autopsy report when performed, and appropriate informed consents.

For patients receiving continuing ambulatory care services, the medical record will contain a summary list(s) of known significant medical diagnoses and conditions, operative and invasive procedures, adverse and allergic drug reactions, and long-term medications, including current medications, over-the-counter drugs, and herbal preparations.

B-2 Orders for medication must be in writing and legible and must be dated, timed and authenticated by the attending/prescribing Practitioner, by another physician who is responsible for the care of the patient, or by a Recognized Medical Affiliate who is authorized by state law and the Bylaws and Rules and Regulations and credentialing policies of the Medical Staff and Hospital to write specific medication orders.

B-3 Symbols and abbreviations may be used only when they have been approved by the Medical Staff and are authorized by Hospital policies and protocols. An official record of approved abbreviations shall be kept on file in the Medical Records Department.

B-4 A complete history and physical examination shall be completed within thirty (30) days before or twenty-four (24) hours immediately after admission or registration, and, for surgical patients, must be done prior to the procedure. The examination shall be recorded in the patient's medical record and should include the patient's medical history, major complaint(s), symptoms and preliminary diagnosis. Any history and physical performed more than thirty (30) days prior to an admission or registration must be re-completed. A history and physical that is more than thirty (30) days old may be entered into the medical record at admission or registration only for historical reference purposes and may not be relied upon with respect to the admission or surgery/invasive procedure. If a history and physical examination has been completed within the thirty (30) day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record to satisfy this requirement; however, in these circumstances, the patient must be evaluated within twenty-four (24) hours after the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record. The update of the history and physical examination must reflect (i) any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition. A history and physical must be completed and documented in the medical record for inpatients and outpatients who are to have surgery, sedation, or other invasive procedures prior to the procedure. Invasive procedures include those in which the patient will have general anesthesia, spinal anesthesia, or regional anesthesia, and where there is major body cavity involvement. The report of the history and physical must be dated and authenticated by the Practitioner in accordance with Section B-1 above of these Rules and Regulations.

B-5 Obstetrical records should include prenatal information and a physical assessment of the mother and the newborn, as applicable. Dental records should include a detailed description of the dental problem and a history and physical examination by a qualified Practitioner.

B-6 A Practitioner's routine orders, when applicable to a particular patient, shall be reproduced or stated in detail on the order sheet of the patient's medical record and shall be authenticated by the Practitioner. A Practitioner may ask another individual to take and transcribe an order on the Practitioner's behalf if the individual is authorized to do so, but the order must be authenticated by the Practitioner as soon as possible, usually within forty eight (48) hours. Orders may be taken by RNs and LPNs and those Recognized Medical Affiliates and Hospital personnel authorized to do so.

B-7 Pertinent progress notes sufficient to permit continuity of care shall be recorded at the time of observation. To the extent possible, each of the patient's clinical problems shall be identified in the progress notes and correlated with specific orders as well as results of diagnostic procedures and other tests and treatment. Progress notes by the attending Practitioner shall be recorded at least every other day except for patients in intensive care, critically ill patients and those where there is difficulty in diagnosis or management of their clinical problems, in which cases progress notes shall be written daily or with such greater frequency as indicated by the patient's condition.

B-8 A relevant, brief report shall be dictated or handwritten as part of the procedure note or recorded prior to initiation of a procedure on all new patients treated by Practitioners performing procedures in the Multi-Service area.

B-9 The operating surgeon shall examine all patients preoperatively. It shall also be his/her duty to see that the surgical records show evidence of adequate preoperative study. The operating surgeon is responsible for writing the preoperative and postoperative orders and appropriate progress notes of the patient's condition.

B-10 In surgical cases and other invasive procedures, the preoperative diagnosis and history and physical examination shall be noted in the patient's medical record in advance of the operation, as required by federal and state law and the Bylaws and Rules and Regulations of the Medical Staff, including Section B-1 and Section B-4 above. The operating surgeon shall record the preoperative diagnosis prior to surgery.

In the event of an emergency, the initial examination of the patient (to include medical history and physical examination, laboratory and x-ray examinations pertinent to the patient's diagnosis and condition at the time of the emergency) will be performed by the attending physician, ED physician, or surgeon. An ED examination may not be used as the history and physical examination required to be performed by Practitioners as required by Section B-1 above.

B-11 Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical techniques. Operative reports shall be dictated and written notes shall be placed in the medical record immediately following surgery for both outpatients and inpatients. The report shall be dated and authenticated by the surgeon and made a part of the patient's medical records.

B-12 Consultation shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinions and recommendations. This report shall be made a part of the patient's medical record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

B-13 A discharge summary shall be written or dictated on all inpatients within thirty (30) days following discharge. The discharge summary should identify the reason for the hospitalization, the significant findings, the procedures performed and treatment provided, the final diagnosis and condition of the patient on discharge, and specific instructions given to the patient and/or a family member, as pertinent, especially those relating to physical activity, medication, diet and follow-up care. When preprinted instructions are given to the patient or a family member, the patient's medical records should so indicate. A final progress note may serve as a discharge summary for a patient with minor health concerns requiring less than forty eight (48) hours' hospitalization or an uncomplicated delivery.

B-14 On the day of discharge, the patient's medical record shall be complete insofar as possible and shall be maintained in the Medical Records Department.

B-15 A medical record shall not be permanently filed until it is completed by the attending Practitioner or is filed by the Medical Records Committee.

B-16 A patient's medical record shall be completed and authenticated as soon as possible and as required by law, and in any event within not more than thirty (30) days following discharge. If a medical record remains incomplete after thirty (30) days following the patient's discharge, it shall be considered delinquent. It shall be the responsibility of the Medical Records Committee to provide written notice to Practitioners who have delinquent records. This responsibility may be carried out by the Medical Records Department, under the direction and oversight of the Medical Records Committee.

B-17 The Medical Records Committee shall monitor the medical record completion practices of Practitioners and refer to the Chief of Staff and the Chair of the Medical Records Committee the names of Practitioners who have failed to complete their patient medical records as required.

B-18 The Medical Executive Committee shall institute any action it deems necessary consistent with the Medical Staff Bylaws and Rules and Regulations, up to and including suspension or revocation of Medical Staff Privileges as to Practitioners reported and verified to be delinquent in completing and maintaining their patient medical records.

B-19 An appropriate medical record shall be kept for every patient receiving emergency service and shall be incorporated in the patient's Hospital record. Emergency services records shall include:

a. Adequate patient identification;

b. Information concerning the time of the patient's arrival, means of arrival, and who transported;

c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his/her arrival at the Hospital;

d. Description of significant clinical, laboratory, and roentgenologic findings;

e. Diagnosis;

f. Home medications;

g. Treatment given;

h. Condition of the patient on discharge or transfer;

i. Final disposition, including discharge instructions given to the patient and/or his/her family, relative to necessary follow-up care; and

j. Signature of the Practitioner completing the report.

B-20 Errors in medical records and medical record entries shall be corrected upon discovery or identification in the following manner. Either a single line shall be drawn through an incorrect or erroneous entry or a notation shall be made where the error was made and the correct entry or data shall be entered on the medical record. The correcting action shall be dated, timed and initialed by the Practitioner or other authorized party making the correcting entry. Under no circumstances shall any entry or data in a medical record be obliterated or destroyed in any manner.

B-21 A late entry or post-discharge note may be recorded in the patient's medical record, but must be so designated by the term "late entry" or "post-discharge note" and shall bear the date and time of the actual entry.

B-22 Written consent of the patient or responsible party is required for release of medical information to persons not otherwise authorized to receive such information, in accordance with federal and state law and Hospital policies.

B-23 Medical records shall not be removed from the Hospital's custody and control except pursuant to a proper court order, subpoena or applicable law. All medical records are the property of the Hospital and shall not be removed without permission of the President. In case of readmission of a patient, all previous medical records shall be available for the use of the attending Practitioner. Unauthorized removal of medical records from the Hospital is grounds for corrective action.

B-24 Access to medical records of patients may be afforded to members of the Medical Staff for bona fide study and research consistent with federal and state laws pertaining to preserving the confidentiality of personal health information of individual patients.

B-25 The Hospital will retain medical records in accordance with its Retention Policy for Medical and Business Records.

PART C. GENERAL CONDUCT OF CARE

C-1 All orders must be in writing, and must be legible, complete, dated, timed and authenticated by the attending, consulting, or prescribing Practitioner or Recognized Medical Affiliate authorized to do so by Missouri law, the Medical Staff Bylaws and Rules and Regulations, and Hospital policies.

When a Practitioner orders a procedure, the order will be understood to authorize Hospital staff to initiate the processes and medications necessary to prepare the patient for the procedure, unless the order specifies otherwise.

Registered dietitians of the Hospital will have the authority to modify a Practitioner's orders to advance a patient's diet and to modify the product and rate of a Practitioner's enteral orders, consistent with Hospital protocols. Certified and registered respiratory therapists of the Hospital will have the authority to implement a Practitioner's orders for ventilator management, consistent with Hospital protocols.

C-2 A Practitioner's orders must be written clearly, legibly, and completely and it is the Practitioner's responsibility to assure that his/her orders are accurate and that they can be understood by Hospital staff and other Practitioners. If an order is illegible or improperly written, it may not be carried out unless it is clarified and rewritten and it is the responsibility of a Practitioner to clarify an order upon request. If an order is to be continued, using the terms "renew," "repeat," and "continue" are not acceptable alternatives to issuing a complete new order. All orders for "prn" and "on call" shall be qualified (i.e., on-call for surgery).

C-3 The use of verbal orders should not be a routine practice and should be limited to situations in which it is impractical for the Practitioner to write the order manually or electronically in accordance with Hospital policy. When a verbal order is given, it may be accepted by/dictated to a Registered Nurse or Licensed Practical Nurse or other Recognized Medical Affiliate or Hospital employee authorized to do so by Missouri law and the Medical Staff Bylaws and Rules and Regulations or applicable Hospital policies. The complete order will be verified by having the person receiving the information record and "read-back" the complete order or test result. All verbal orders will include the date and time of entry into the medical record, identify the names of the individuals who gave, received, and implemented the order, and then be authenticated (i.e., verified, signed, dated and times) by the ordering Practitioner within forty-eight (48) hours of issuing the order, except that a verbal order that is issued for a short duration or pertains to a matter that is of particular sensitivity and significance to patient care (which include

"do not resuscitate," restraint/seclusion and stat orders) must be authenticated within twenty-four (24) hours.

C-4 All orders for medications will (i) be in writing, dated, timed and authenticated by the Practitioner responsible for the care of the patient (with the exception of influenza and pneumococcal vaccines, which may be administered per Hospital policy after an assessment for contraindications), and (ii) contain the elements of a complete order, including the name of the drug (generic or brand name), its strength and dosage form (when applicable), the route of administration, and the dosage regimen. Orders for medications that require titration must identify the desired results for the patient (i.e., titrate medication to maintain systolic BP greater than 90). For each medication that is ordered by a Practitioner, the diagnosis, medical condition, or other indication for the prescription should be documented in the patient's medical record.

Adverse medication reactions, incompatibilities, transfusion reactions, and errors in administration of medications will be immediately documented in the patient's medical record and reported to the attending Practitioner and, if appropriate, to the appropriate departments and individuals within the Hospital.

C-5 All medications with an order life of thirty (30) days or more or without specific time limits must be rewritten or discontinued as of thirty (30) days; except that ketorolac will be discontinued as of five (5) days with notification given to the prescribing physician or other attending Practitioner by the Pharmacy Department.

Prescriptions for drug therapy will not be discontinued without notifying the Practitioner who ordered the medication or other attending Practitioner. Hospital pharmacists will have the authority to modify medication orders and to authorize appropriate laboratory tests when a Practitioner requests pharmacy based dosing.

Drugs and biologicals will be maintained in secure areas, and will be kept in locked areas when appropriate, such as with controlled substances.

C-6 If a medication order expires at night, it will be continued and called to the attention of the Practitioner the following morning. It is the Practitioner's responsibility to thereafter rewrite or discontinue the order.

C-7 All previous medication orders will be discontinued when a patient goes to surgery. It is the Practitioner's responsibility to rewrite orders as appropriate for the patient's continued care.

C-8 Drugs that are stocked by the Hospital pharmacy (formulary drugs) must be approved by the Pharmacy and Therapeutics Committee. A listing of the formulary drugs will be made available to a Practitioner upon request.

Generic drugs or other medications that have been reviewed and approved for use by the Pharmacy and Therapeutics Committee shall be used unless the prescribing physician

indicates that he/she does not concur with the use of an alternative formulary drug by writing "no substitution" on the physician's order.

If a Practitioner requests a drug that is not on the formulary and if the Pharmacy and Therapeutics Committee has not approved an equivalent medication, then the Hospital pharmacy will contact the prescribing physician to determine if an alternative formulary drug may be dispensed. If it is not acceptable to the Practitioner to substitute a formulary drug, then the Hospital pharmacy will obtain the non-formulary product.

A Practitioner may submit a written request to the Hospital pharmacy at any time to add a drug to the formulary. The Hospital pharmacy will ask the Pharmacy and Therapeutics Committee to review the matter and determine whether the drug should be added to the formulary.

C-9 Patients may be permitted to self-administer specific hospital-issued medications, pursuant to hospital policy which (i) ensures that a practitioner responsible for the care of the patient has issued an appropriate order; (ii) requires the assessment of the capacity of the patient (or the patient's caregiver) to self-administer the specified medication(s); (iii) requires that the patient (or the patient's caregiver) be instructed in the safe and accurate administration of the specified medication(s); (iv) addresses the security of the medication(s) for each patient; (v) provides for the documentation of the administration of each medication, as reported by the patient (or the patient's caregiver), in the patient's medical record.

C-10 Patients may be permitted to self-administer their own specific medication(s) brought into the hospital, pursuant to hospital policy which (i) ensures that a practitioner responsible for the care of the patient has issued an appropriate order; (ii) requires the assessment of the capacity of the patient (or the patient's caregiver) to self-administer the specified medication(s) and determines if the patient (or the patient's caregiver) need instruction on the safe and accurate administration of the specified medication(s); (iii) requires the identification of the specified medication(s) and the visual evaluation of the medication for integrity; (iv) addresses the security of the medication(s) for each patient; (v) provides for the documentation of the administration of each medication, as reported by the patient (or the patient's caregiver), in the patient's medical record. If the patient's own medications are not allowed, the patient will be informed of that decision and the medications will be packaged, sealed, and returned to the patient or given to the patient's representative at the time of discharge from the Hospital.

C-11 An attending Practitioner may consult with another Practitioner about a patient's medical condition when a specialist's services are warranted or when necessary to assure continuity of care. It is the responsibility of the attending Practitioner to assure that another Practitioner is advised of the request for consultation or assessment of a patient, including providing appropriate written authorization or another Practitioner to attend or examine a patient. Practitioners other than those who have received such authorization should not have Patient Contact except in an emergency.

C-12 Laboratory work and radiology and diagnostic imaging services shall be performed on a patient only on the orders of a Practitioner. Orders for outpatient services may be accepted from licensed health care professionals who are not members of the Medical Staff at the Hospital in accordance with Hospital policy.

C-13 A patient should not be physically restrained or placed in seclusion without the specific order of a Practitioner that specifies the reason and, if restraint is needed for behavioral reasons, the circumstances and duration in which restraints or seclusion are to be used. Orders for restraint or seclusion may not be issued as standing orders or PRN orders. A patient may be physically or chemically restrained only if it is necessary to improve his/her well-being and less restrictive interventions will not be effective to protect the patient or others from harm or the use of restraints is consistent with medically necessary treatment. In an emergent situation, a nurse may initiate the use of restraints or seclusion for behavioral reasons but must promptly inform and seek an order from a Practitioner regarding the need for the procedure. A Practitioner must directly and in person assess the patient within one (1) hour and write an order that either confirms, modifies or cancels the need to use restraints or seclusion for the patient. An order for restraints or seclusion is limited to four (4) hours for adults, two (2) hours for children between the ages of nine (9) and seventeen (17), and one (1) hour for children under the age of nine (9).

C-14 If a patient's attending Practitioner cannot be located and restraints or seclusion are thought to be urgent in order to protect the patient, staff or other patients, the Chief of Staff, the chief of the appropriate department, or another Practitioner shall have the authority to assess the patient and issue such orders.

C-15 Members of the Medical Staff will cooperate with Hospital staff in complying with the requirements of 42 CFR 482.45 and 194.210 RSMo., et seq., pertaining to organ, tissue and eye donations. In the interest of complying with these requirements, Practitioners will assist Hospital staff in ensuring that an Organ Procurement Organization is contacted in a timely manner in appropriate circumstances.

C-16 Practitioners shall perform medication reconciliation to determine which home medications should be continued while a patient is hospitalized. Medication reconciliation shall be performed at the time of a patient's admission, when the patient's level of care changes (including transfers between ICU units and medical-surgical areas), and at the time of discharge (including to the Rehabilitation Unit).

C-17 The MEC will review and approve standing orders, order sets and protocols. Where appropriate, input should be sought from nursing and pharmacy. Prior to approval, the MEC shall confirm that the standing orders, order sets and protocols are consistent with nationally recognized and evidence-based guidelines. The MEC shall also take appropriate steps to ensure that there is a periodic and regular review of such orders and protocols.

When used, standing orders, order sets and protocols must be dated, timed, and authenticated promptly in the patient's medical record by the ordering Practitioner or by another Practitioner responsible for the care of the patient.

PART D. GENERAL RULES REGARDING SURGICAL CARE

D-1 Surgery shall be performed by surgeons according to the Privileges recommended by the Boone Hospital Center Medical Staff and granted them by the Board of Directors recorded on the roster of surgical Privileges maintained in the Operating Room.

D-2 A patient admitted for dental care other than oral or maxillofacial surgery is a dual responsibility involving the dentist and a physician who is a member of the Medical Staff.

a. Dentist's responsibilities:

(1) A detailed dental history justifying hospital admission.

(2) A detailed description of the examination of the oral cavity and preoperative diagnosis.

(3) A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.

(4) Progress notes as are pertinent to the oral condition.

(5) Clinical resume (or summary statement).

b. Physician's responsibilities:

(1) Medical history pertinent to the patient's general health.

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

(3) Supervision of the patient's general health status while hospitalized.

c. The discharge of the patient shall be on written order of the dentist subject to confirmation by the responsible physician member of the Medical Staff.

D-3 A patient admitted for podiatric care is a dual responsibility involving the podiatrist and a physician who is a member of the Medical Staff.

a. Podiatrist's responsibilities:

(1) A detailed podiatric history justifying hospital admission.

(2) A detailed description of the examination and preoperative diagnosis.

(3) A complete operative report, describing the findings and technique.

(4) Progress notes as are pertinent to the podiatric condition.

(5) Clinical resume (or summary statement).

b. Physician's responsibilities:

(1) Medical history pertinent to the patient's general health.

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

(3) Supervision of the patient's general health status while hospitalized.

c. The discharge of the patient shall be on written order of the podiatrist subject to confirmation by the responsible physician member of the Medical Staff.

D-4 A surgical operation shall be performed only with the written, signed, informed consent of the patient or his/her authorized representative except in an emergency. In the case of an emergency where the patient lacks the capacity or is unable to give informed consent or is a minor, and there is no available person who is authorized to consent to surgical or medical treatment for the patient, the operative surgeon and, when possible, another qualified Practitioner should verify in the patient's medical record that the operation is considered an emergency and that any delay occasioned by attempts to obtain a signed informed consent is reasonably expected to jeopardize the life, health or limb of the patient or result in disfigurement or impairment of faculties.

D-5 The operating surgeon is responsible for informing the patient or his/her authorized representative about the nature and purpose of the procedures to be performed or treatment planned for the patient. The Practitioner performing the procedure also has the responsibility of informing the patient about anticipated benefits, risks, likely complications, and alternative methods available. In discharging this responsibility, the Practitioner should be guided by a concern for the patient's overall well-being and awareness of the patient's right to be informed about the procedure, the patient's clinical condition, and his/her mental and physical status and ability to comprehend the risks, benefits and alternatives to the proposed procedure. Failure to comply with this requirement may result in a review by the Medical Executive Committee of the Practitioner's professional practices. Procedures requiring special written consent include, but are not limited to, the following:

a. Major or minor surgery involving any entry into the body, either through incision or through a natural body opening;

b. All procedures in which anesthesia is used, regardless of whether an entry into the body is involved;

c. All forms of radiological therapy;

d. Electroconvulsive therapy;

e. All experimental procedures; and

f. All other procedures which, in the judgment of the responsible Practitioner, require a specific explanation to the patient.

Any doubt as to the necessity of obtaining a special consent for any procedure should be resolved in favor of procuring the consent.

D-6 The responsible operating surgeon shall examine the patient preoperatively, state his/her findings and preoperative diagnosis, and write the pre and post-operative orders. He/she is also responsible for daily visits to the patient and for notes on the surgical convalescence. The patient must know which of the physicians is attending him, and which is the responsible operating surgeon and must consent specifically to the operation by the responsible operating physician.

D-7 As part of his or her routine professional practices, the responsible operating surgeon is expected to engage in pre-operative verification of the identity of the patient, the surgical site, test results, and the procedure to be performed. Pre-operative verification should include ensuring that relevant documents are available and that these documents are consistent with the patient's expectations and the health care team's understanding of the procedure to be performed. The site of the incision or insertion must be marked clearly and accurately, consistent with national safety guidelines.

D-8 The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia (i.e., a Practitioner with Clinical Privileges or a Recognized Medical Affiliate with a Scope of Practice that allows him/her to administer anesthesia) within forty-eight (48) hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services. The evaluation will be recorded in the medical record and will include:

(1) a review of the medical history, including anesthesia, drug and allergy history;

(2) an interview and examination of the patient;

(3) notation of any anesthesia risks;

(4) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway);

(5) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits); and

(6) any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

D-9 All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status. All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including: the name and Hospital identification number of the patient; the name of the Practitioner or Recognized Medical Affiliate who administered anesthesia and, as applicable, any supervising Practitioner; the name, dosage, route time, and duration of all anesthetic agents; the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices; the name and amounts of IV fluids, including blood or blood products, if applicable; time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and any complications, adverse reactions or problems occurring during anesthesia and the patient's status upon leaving the operating room.

D-10 In all cases, a post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia (i.e., a Practitioner with Clinical Privileges or a Recognized Medical Affiliate with a Scope of Practice that allows him/her to administer anesthesia) no later than forty-eight (48) hours after the patient has been moved into the designated recovery area. The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient's medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the forty-eight (48) hour time frame and a notation documenting the reasons for the patient's inability to participate will be made in the medical record. The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including: respiratory function; cardiovascular function; mental status; temperature; pain; nausea and vomiting; and post-operative hydrations.

D-11 An operative procedure report must be dictated immediately after an operative procedure and entered into the record. The operative procedure report shall include: the patient's name and hospital identification number; pre- and post-operative diagnoses; date and time of the procedure; the name of the responsible operating surgeon and assistant

surgeon(s) responsible for the patient's operation; procedure(s) performed and description of the procedure(s); description of the specific surgical tasks that were conducted by practitioners other than the responsible operating surgeon; findings; estimated blood loss; any unusual events or complications, including blood transfusion reactions and the management of those events; the type of anesthesia/sedation; specimen(s) removed, if any; and prosthetic devices, grafts, tissues, transplants, or devices implanted (if any).

If a dictated report cannot be entered into the record immediately after the operation or procedure, a progress note containing the information below must be entered in the medical record immediately after the procedure and authenticated by the responsible operating surgeon. The note must record the names of the physician(s) responsible for the patient's care and physician assistants; procedure(s) performed; findings; estimated blood loss, when applicable or significant; specimens removed; and post-operative diagnosis.

D-12 Patients will be discharged from the recovery area by a qualified Practitioner or a Recognized Medical Affiliate or according to criteria approved by the clinical leaders. Post-operative documentation will record the patient's discharge from the post-anesthesia care area and record the name of the individual responsible for discharge. Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.

D-13 All tissues removed at the time of operation shall be sent to the Hospital pathologist. The pathologist's authenticated, dated report shall be made a part of the patient's medical record.

PART E. EMERGENCY SERVICES

E-1 The Practitioners in the Emergency Medicine Department shall be responsible for the professional care of all patients seeking medical care through the Emergency Department, until a patient is discharged or responsibility for the patient's care is assumed by another Practitioner. These Practitioners shall provide medical services for all patients who present at the Hospital for emergency care, as is appropriate and as is required by law.

E-2 The Emergency Medicine Department shall assemble a procedure manual defining the duties and responsibilities of all personnel servicing patients within the emergency area.

E-3 An appropriate medical record shall be kept for every patient receiving emergency service, which will be incorporated in the patient's Hospital record. The record shall include the items identified in Section B-19 of these Rules.

E-4 Each emergency medical record shall be signed by the Practitioner or Recognized Medical Affiliate who provided medical care to the patient. This Practitioner or Recognized Medical Affiliate will be responsible for its clinical accuracy.

E-5 There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed in cooperation with the Medical Executive Committee, the Vice President for Nursing or her designee, and a representative from Hospital Administration. The Emergency Preparedness Plan shall be maintained by the Emergency Preparedness Committee and shall be available to all members of the Medical Staff in the Emergency Medicine Department and other locations in the Hospital.

E-6 The Emergency Preparedness Plan should be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the Medical Staff, as well as Administrative, Nursing, and other Hospital personnel. A written report and evaluation of all drills shall be made.

E-7 Members of the Active Staff except those Practitioners who are members of the group contracted to cover the Emergency Medicine Department, and dentists and podiatrists, have an obligation, but not a right, to share on-call duties. Medical Staff members who are relieved of on-call responsibilities for any reason may be assigned other duties so that all members share as equitably as possible in Medical Staff responsibilities. Removing a member from the on-call schedule, for any reason, does not trigger the hearing and appeals procedures in the Medical Staff Bylaws.

E-8 When a Member of the Medical Staff is on call and is contacted by the Emergency Medical Department, the Member must:

(a) be immediately available to the Emergency Medicine Department; and

(b) respond in person, if so requested, within a reasonable time period. Generally, response is expected within a range of 30 to 45 minutes. The ED physician, in consultation with the on-call physician, will determine whether the patient's condition requires the on-call physician to see the patient as soon as possible. The determination of the ED physician will be controlling and will be recorded in the medical record.

Members who are on call should not inquire about the individual's insurance status or ability to pay before coming to the Emergency Medicine Department.

E-9 The Emergency Medicine Department of the Medical Staff shall develop, in conjunction with the Hospital, policies and procedures to be followed when a particular specialty is unavailable or the on call physician cannot respond because (i) a situation arose beyond his or her control, or (ii) if permitted by the Hospital, he or she is performing elective surgery or other procedures at the Hospital while on call or is simultaneously on call at another hospital.

E-10 A medical examination will be provided to all persons who present to the Hospital requesting examination or treatment for a perceived emergency medical condition. The

medical screening examination will be performed by a physician or other licensed health care provider who is identified by the Hospital and the Medical Staff policies, procedures and protocols as being qualified to provide this examination.

PART F. CODE OF CONDUCT

In exercising Clinical Privileges or a scope of practice in the Hospital, Practitioners and Recognized Medical Affiliates will be expected to conduct themselves in accordance with applicable professional and legal requirements. It is expected that each Practitioner and Recognized Medical Affiliate will:

- cooperate with other physicians and hospital staff and provide services with professionalism, integrity, honesty, and courtesy;
- comply with federal and state statutes and regulations and certification standards that apply to the services;
- comply with the Medical Staff Bylaws and Rules and Regulations and the administrative policies of the Hospital that apply to the services;
- provide medical care in accordance with generally recognized standards of care, consistent with the wishes of patients or their family members or other surrogate decision makers;
- coordinate the medical treatment provided with other health care providers and consult with other providers when a patient's condition warrants it;
- not engage in behavior that can be expected to impair the ability of other members of the healthcare team to provide high quality care or creates a hostile or intimidating work environment; and
- not engage in acts of retaliation against hospital staff or physicians who report concerns about his/her behavior or about the medical care he/she has provided.

To aid in the education of Practitioners and Recognized Medical Affiliates, the following, when directed toward patients, employees or other Practitioners, are inappropriate conduct and may be behaviors that undermine a culture of safety:

- threatening or abusive language directed at patients, nurses, Hospital personnel, Practitioners or other Recognized Medical Affiliates (e.g., belittling, berating, and/or threatening another individual) and non-constructive criticism that intimidates, undermines confidence, or implies incompetence;
- degrading or demeaning comments regarding patients, families, nurses, Practitioners, other Recognized Medical Affiliates, Hospital personnel, or the Hospital;

- profanity or similarly offensive language while in the Hospital and/or while speaking with nurses or other Hospital personnel;

- inappropriate physical contact with another individual that is threatening or intimidating;

- inappropriate medical record entries concerning the quality of care being provided by the Hospital or any other individual or otherwise critical of the Hospital, other Practitioners or personnel;

- refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws and Medical Staff Rules and Regulations, and/or Credentials Manual and Hearing and Appeals Procedures Manual, as applicable (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the Medical Staff and the Hospital Staff);

- "sexual harassment" which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. Examples include, but are not limited to, the following:

  (a) Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;

  (b) Visual/Non-Verbal: derogatory posters, cartoons, e-mails, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;

  (c) Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and

  (d) Other: making or threatening retaliation as a result of an individual's negative response to harassing conduct.

- "harassment" includes unwelcome and offensive conduct related to an individual's race, color, religion, gender (including pregnancy), age, disability, national origin, citizenship, or other protected characteristic. As above, these forms of unlawful harassment may be verbal, non-verbal/visual, physical, or other in nature.

EXHIBIT C

Planned Parenthood

Cohen, Melissa <melissa.cohen@ppfa.org>

RE: hospital by-laws

1 message

McQuade, Laura [redacted] Tue, Oct 11, 2016 at 1:19 PM
To: [redacted]@tmcmed.org>

[redacted],

One of my team members, [redacted], forwarded me your response regarding our request to receive a copy of Truman's staff bylaws. One of our physicians, Ronald Yeomans, is interested in applying to Truman for privileges, as we have a nearby health care facility. He would like to review your requirements before deciding whether to submit his application. Would you please share the bylaws or advise me on your process for privileging physicians?

Thank you for your consideration.

Best,

Laura McQuade

President & CEO

Planned Parenthood Great Plains (PPGP)

Planned Parenthood Great Plains Votes (PPGPV)

[redacted]

[redacted]

[redacted]

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Planned Parenthood Act. No matter what. Planned Parenthood Great Plains Votes

---

From: [redacted]@tmcmed.org]
Sent: Tuesday, October 04, 2016 4:05 PM
To: [redacted]
Subject: RE: hospital by-laws

[redacted],

Thanks for reaching out to us. I'm afraid that [redacted] might not have known, but we are a private corporation and do not distribute the Bylaws outside the facility.

Sorry that I can't be of more assistance.

Thanks,

[redacted]

[redacted]
Associate General Counsel
Truman Medical Centers
(816) 404-3637 | [redacted]@tmcmed.org

PP Great Plains works to ensure that every individual has the knowledge opportunity and freedom to make informed, private decisions about reproductive and sexual health.

Planned Parenthood Great Plains

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EXHIBIT D

Planned Parenthood

Cohen, Melissa <melissa.cohen@ppfa.org>

RE: Hospital Bylaws

1 message

McQuade, Laura [redacted] Tue, Oct 11, 2016 at 1:10 PM
To: '[redacted]@saint-lukes.org>

Thanks so much for this response, [redacted]. Dr. Yeomans went ahead and requested an application online on October 5th. If you would go ahead and send the relevant documents for us to review as he decides whether to apply, I would greatly appreciate it.

Best,

Laura McQuade

President & CEO

Planned Parenthood Great Plains (PPGP)

Planned Parenthood Great Plains Votes (PPGPV)

[redacted]

[redacted]

[redacted]

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From: [redacted]@saint-lukes.org]
Sent: Thursday, September 29, 2016 1:41 PM
To: McQuade, Laura <[redacted]>
Subject: FW: Hospital Bylaws

Hello – we do not forward the Medical Staff Bylaws until an application is requested. Here is a recap of items that might meet your needs.

- Application Fee $550
- MO License
- MO BNDD
- MO DEA
- Certificate of Insurance: $1 million individual/$3 million aggregate coverage
- Current Board Certification
- Alternate Provider(s)
- 10 year professional liability claim history
- 2 years clinical activity/procedure log
- CME for the past year
- ER Call
- Epic training (EMR) completion
- Documentation of annual influenza vaccination
- Annual medical staff Dues ($200 in 2016; amount determined each year)

A link to the request for application to SLHS hospitals is: http://www.saintlukeshealthsystem.org/medical-staffallied-health-staff-credentialing

Please let me know if there are questions regarding the above or if there are specific additional questions.

Thank you.

[redacted]

[redacted] | Manager, SLH Medical Staff Services| [redacted]

-----Original Message-----
Fr**om:** McQuade, Laura [redacted]
Sent: Wednesday, September 28, 2016 05:42 PM Central Standard Time
To**:** [redacted]
Subject: Hospital Bylaws

This message originated outside of Saint Luke's Health System's email system [redacted]USE CAUTION when clicking on any web links or opening any attachments.

Dear [redacted],

I am writing on behalf of Dr. Ronald Yeomans to request a copy of the staff bylaws for St. Luke's Hospital, as Dr. Yeomans is interested in what the requirements are to apply for privileges. If you could please forward any relevant credentialing documents on to me I would appreciate it.

Best,

Laura McQuade

President & CEO

Planned Parenthood Great Plains (PPGP)

Planned Parenthood Great Plains Votes (PPGPV)

[redacted]

[redacted]

[redacted]

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<="" img="">

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Planned Parenthood Great Plains

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EXHIBIT E

Cohen, Melissa <melissa.cohen@ppfa.org>

RE: Medical Staff Bylaws

1 message

McQuade, Laura [redacted]
To: [redacted]@kumc.edu>

Tue, Oct 4, 2016 at 6:52 PM

[redacted]

Thank you very much for passing along the bylaws. I noticed that they refer to three other documents that seem to have additional information regarding requirements that physicians must meet in order to get and maintain privileges, and it would be very helpful to see those as well. Specifically, can you please provide the Credentialing Procedures of the Medical Staff, the FPPE Policy, and the OPPE Policy?

Thank you again for your assistance.

Best,

Laura

President & CEO

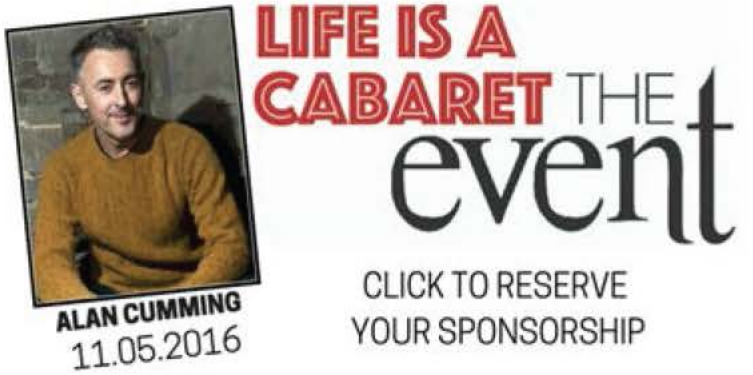
Planned Parenthood Great Plains (PPGP)

Planned Parenthood Great Plains Votes (PPGPV)

[redacted]

[redacted]

[redacted]



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From: [redacted]@kumc.edu]
Sent: Friday, September 30, 2016 11:12 AM
To: McQuade, Laura [redacted]
Subject: Medical Staff Bylaws

Attached are our current Medical Staff Bylaws as requested.

[redacted] CPMSM, CPCS

Director, Medical Staff Affairs

The University of Kansas Hospital

3901 Rainbow Blvd., MS 3023

Kansas City, KS 66160

[redacted]

[redacted]

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THE UNIVERSITY OF KANSAS HOSPITAL

BYLAWS OF THE MEDICAL STAFF

Adopted August 27, 1998 by the Medical Staff of the
The University of Kansas Hospital
Adopted September 14, 1998 by the Board of Directors of the
University of Kansas Hospital Authority

Amendments approved February 28, 2002 by the Medical Staff of the
University of Kansas Hospital
Amendments approved March 12, 2002 by the Board of Directors of the
University of Kansas Hospital Authority

Amendments approved May 12, 2003 by the Medical Staff of the
University of Kansas Hospital
Amendments approved May 13, 2003 by the Board of Directors of the
University of Kansas Hospital Authority

Amendments approved June 24, 2004 by the Medical Staff of the
University of Kansas Hospital
Amendments approved June 30, 2004 by the Board of Directors of the
University of Kansas Hospital Authority

Amendments approved October 19, 2004 by the Medical Staff of the
University of Kansas Hospital
Amendments approved November 9, 2004 by the Board of Directors of the
University of Kansas Hospital Authority

Bylaws reviewed with no changes recommended as of April 20, 2006 by the
Medical Staff of the University of Kansas Hospital

Amendments approved May 22, 2008; November 20, 2008 by the Medical Staff of the
University of Kansas Hospital
Revisions approved by the University of Kansas Hospital Authority
Board of Directors August 12, 2008; January 13, 2009

Amendments approved March 26, 2009; November 19, 2009 by the Medical Staff of the
University of Kansas Hospital
Amendments approved by the University of Kansas Hospital Authority
Board of Directors April 14, 2009; January 12, 2009

Amendments approved February 28, 2011 by the Medical Staff of the
University of Kansas Hospital
Amendments approved by the University of Kansas Hospital Authority
Board of Directors March 8, 2011

Amendments approved May 30, 2012 by the Medical Staff of the
University of Kansas Hospital
Amendments approved by the University of Kansas Hospital Authority
Board of Directors June 12, 2012

Amendments approved November 29, 2013 by the Medical Staff of the
University of Kansas Hospital
Amendments approved by the University of Kansas Hospital Authority
Board of Directors December 10, 2013

TABLE OF CONTENTS

ARTICLE I: PURPOSE

The purpose of this organization is to bring the professionals who practice at the University of Kansas Hospital (the "Hospital") together into a cohesive body to promote excellent patient care. To this end, among other activities, it will evaluate applicants for Medical Staff membership, review privileges of members, evaluate and assist in improving the work performed by the Medical Staff, provide education appropriate to Medical Staff activities, and provide an appropriate educational setting that will encourage clinical and basic research.

ARTICLE II: CATEGORIES OF THE MEDICAL STAFF

Successful acquisition and retention of Medical Staff membership and clinical privileges is a matter to be recommended by the Medical Staff and approved by the Board of Directors ("Board") of the University of Kansas Hospital Authority ("Hospital Authority") in accordance with the Credentialing Procedures of the Medical Staff. Except for individuals appointed to the Honorary staff described in Part E below, all initial appointments to the Medical Staff shall be to the Provisional category described in Part A below for at least one (1) year. Thereafter, all individuals who have completed at least one (1) year of satisfactory performance as a Provisional staff member shall be eligible for appointment to either the Active, Courtesy, or Volunteer staff, as described below in Parts B, C, and D respectively.

PART A: PROVISIONAL

Section 1. Qualifications

The Provisional staff shall consist of those doctors of medicine and osteopathy licensed in accordance with K.S.A. § 65-2801 et seq., and dentists licensed in accordance with K.S.A § 65-1421 et seq., who are members of the faculty of the University of Kansas School of Medicine (the "Medical School").

Section 2. Obligations

Persons appointed to the Provisional staff shall regularly attend Medical Staff and committee meetings, serve on appropriate Medical Staff and Hospital committees as appointed, participate in quality review, education, risk management, and utilization review activities of the Medical Staff and Hospital, and perform assigned on-call duties and assignments.

Section 3. Prerogatives

Persons appointed to the Provisional staff may exercise those clinical privileges granted, and may, except for dentists and other appointees anticipated to be appointed to the Volunteer staff following their Provisional status, admit patients to the Hospital. Except as provided in Article IV, Part B, Section 1 of these Bylaws, Provisional staff members shall not vote on matters presented at general and special meetings of the Medical Staff and shall not hold office.

PART B: ACTIVE

Section 1. Qualifications

The Active staff shall consist of those doctors of medicine and osteopathy licensed in accordance with K.S.A. § 65-2801 et seq. who are members of the faculty of the Medical School and who regularly admit to or are otherwise regularly involved in the treatment or evaluation of patients at the Hospital. Persons appointed to the Active staff shall have completed at least one (1) year of satisfactory performance as a Provisional staff member.

Section 2. Obligations

Persons appointed to the Active staff shall regularly attend Medical Staff and committee meetings, serve on appropriate Medical Staff and Hospital committees as appointed, participate in quality review, education, risk management, and utilization review activities of the Medical Staff and Hospital, and perform assigned on-call duties and assignments.

Section 3. Prerogatives

Persons appointed to the Active staff may admit patients to the Hospital, exercise those clinical privileges granted, vote on matters presented at general and special meetings of the Medical Staff, hold office, serve as voting members on Medical Staff committees to which they are appointed or elected, and serve as chairpersons of such committees.

PART C: COURTESY

Section 1. Qualifications

The Courtesy staff shall consist of those doctors of medicine and osteopathy licensed in accordance with K.S.A. § 65-2801 et seq. who are members of the faculty of the Medical School, who possess adequate clinical and professional expertise, but who do not regularly attend to or admit patients to the Hospital. Courtesy staff members must document their admission or involvement in the care or treatment of patients at the Hospital or at other primary practice sites (e.g., other hospitals or clinics) and shall have completed at least one (1) year of satisfactory performance as a Provisional staff member.

Section 2. Obligations

Persons appointed to the Courtesy staff may be required to perform assigned on-call duties and assignments if deemed necessary by the Clinical Service Chief of the Clinical Service in which the Courtesy staff member is assigned.

Section 3. Prerogatives

Persons appointed to the Courtesy staff may admit patients to the Hospital and exercise those clinical privileges granted. Courtesy staff members may attend general and

special Medical Staff meetings without a vote. Courtesy staff may serve as non-voting members on Medical Staff committees to which they are appointed, unless a right to vote within the committee is specified by the Chief of Staff upon a member's appointment to the committee. Courtesy staff members shall not hold office.

PART D: VOLUNTEER

Section 1. Qualifications

The Volunteer staff shall consist of those doctors of medicine and osteopathy licensed in accordance with K.S.A. § 65-2801 et seq., and dentists licensed in accordance with K.S.A. § 65-1421 et seq., who possess adequate clinical and professional expertise, but who are not authorized to admit patients to the Hospital. Volunteer staff members must document their involvement in the care or treatment of patients at the Hospital or at other primary practice sites (e.g., other hospitals or clinics) and shall have completed at least one (1) year of satisfactory performance as a Provisional staff member.

Section 2. Obligations

Persons appointed to the Volunteer staff may be required to perform assigned on-call duties and assignments if deemed necessary by the Clinical Service Chief of the Clinical Service in which the Volunteer staff member is assigned.

Section 3. Prerogatives

Persons appointed to the Volunteer staff may exercise those clinical privileges granted. Volunteer staff members may attend general and special Medical Staff meetings without a vote and serve as non-voting members on Medical Staff committees to which they are appointed. Volunteer staff members shall not hold office.

PART E: HONORARY

Section 1. Qualifications

The Honorary staff shall consist of those doctors of medicine and osteopathy who are members of the faculty of the Medical School, who have retired from the active practice of medicine, that wish to continue to participate in administrative activities.

Section 2. Prerogatives

Persons appointed to the Honorary staff may attend general Medical Staff meetings and serve on committees to which they are duly appointed, but may not admit patients to the Hospital, exercise clinical privileges or otherwise treat or evaluate patients, or vote on any matters presented at meetings of the Medical Staff. Honorary staff may serve as non-voting members on Medical Staff committees to which they are appointed, unless a right to vote within the committee is specified by the Chief of Staff upon a member's appointment to the committee.

ARTICLE III: ORGANIZATION OF THE MEDICAL STAFF

PART A: MEDICAL STAFF YEAR

For the purpose of these Bylaws, the Medical Staff Year commences each year on the first day of July and ends on the 30th day of June in the following year.

PART B: OFFICERS OF THE MEDICAL STAFF

Section 1. Identity and Qualifications of Officers

The officers of the Medical Staff shall be the Chief of Staff, Immediate Past Chief of Staff, Vice Chief of Staff, Secretary, and three Elected Representatives of the Medical Staff. All must be members of the Active staff at the time of their nomination and election and during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 2. Duties of Officers

A. The Chief of Staff

The Chief of Staff shall:

1. Be responsible to the Board as the chief administrative officer of the Medical Staff;

2. Preside at all meetings of the Medical Staff;

3. Serve as chair of the Executive Committee;

4. Appoint, after consultation with the CEO of the Hospital, the membership of, designate the chairs of, and serve as an ex officio nonvoting member of all standing or ad hoc committees of the Medical Staff in accordance with the Medical Staff Committee Procedures;

5. Serve as a member of the Board in accordance with the Bylaws of the Hospital Authority;

6. Communicate and represent the opinions, policies, concerns and needs of the Medical Staff to the Board, the CEO of the Hospital, the Executive Dean of the Medical School (the "Dean") and the other officers of the Medical Staff;

7. Receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality

patient care;

8. Enforce the Bylaws, Rules and Regulations, and other policies and procedures of the Medical Staff;

9. Work with the Dean in directing the activities of the Medical Staff to foster the appropriate educational and research environment at the Hospital; and

10. Perform all other functions specifically delegated to the Chief of Staff in these Bylaws.

B. The Immediate Past Chief of Staff

The Immediate Past Chief of Staff shall:

1. Consult with the Chief of Staff and Vice Chief of Staff, as requested, on matters relating to the duties of such officers;

2. Perform such duties as are delegated to the Immediate Past Chief of Staff by the Chief of Staff or the Vice Chief of Staff in the Absence of the Chief of Staff; and

3. Serve on Medical Staff committees as requested by the Chief of Staff.

C. The Vice Chief of Staff

The Vice Chief of Staff shall:

1. Assume all the duties and have the authority of the Chief of Staff in the absence of the Chief of Staff;

2. Serve as a member of the Executive Committee; and

3. Perform such duties as are delegated to the Vice Chief of Staff by the Chief of Staff.

D. Secretary

The Secretary shall:

1. Serve as a member of the Executive Committee;

2. Keep accurate and complete minutes of all Executive Committee and Medical Staff meetings;

3. Call Medical Staff meetings on order of the Chief of Staff or the Vice Chief of Staff if acting as the Chief of Staff; and

4. Attend to all correspondence and perform such other duties as ordinarily pertain to the office of Secretary.

E. Elected Representatives of the Medical Staff

Each of the three Elected Representatives shall:

1. Serve as a member of the Executive Committee; and

2. Perform such functions as may be delegated to them by the Chief of Staff.

Section 3. Election and Terms of Officers and Elected Representatives

A. Nomination

All elected officers of the Medical Staff will be elected from the slate of candidates presented by the Nominations and Elections Committee at the Annual Meeting or from those additional nominations proposed from the floor at the Annual Meeting. The Immediate Past Chief of Staff is not elected.

B. Election

1. Not later than five (5) business days after the Annual Meeting, the Nominations and Elections Committee shall prepare and deliver to each member of the Active staff a written or electronic ballot form ("primary ballot") clearly indicating the position(s) to be elected, the candidates nominated for each position, the date by which the ballot must be returned, and the physical or e-mail address to which the ballot must be returned.

2. Within ten (10) business days after the Annual Meeting, members of the Active staff shall return their marked ballots to the Nominations and Elections Committee at the address indicated on the ballot.

3. Within thirty (30) business days after the Annual Meeting, the Nominations and Elections Committee shall tally the results and announce the winners of the election. Winners shall be those receiving a majority of votes cast.

4. In the event no candidate receives a majority of votes cast, the Nominations and Elections Committee shall, within five (5) business days after announcing the election results, prepare and deliver to each member of

the Active staff, a written or electronic ballot form ("runoff ballot") listing the positions for which no candidate received a majority of votes cast, the two candidates receiving the greatest number of votes for each such position, the date by which ballots must be returned, and the physical or e-mail address to which ballots must be returned. The Active staff shall have fifteen (15) business days from the date the results of the initial election are announced to return their runoff ballots to the Nominations and Elections Committee at the address indicated on the ballot.

5. The time period between an Annual Meeting and either the completion of the election process or the end of the Medical Staff Year, whichever occurs last, shall be termed an "Election Period."

C. Terms of Office

With the exception of the Immediate Past Chief of Staff, each officer shall serve a term of three years and may be re-nominated and re-elected for up to two consecutive terms, or for non-consecutive terms without limitation. The Immediate Past Chief of Staff shall serve a term of one year, following which the office of Immediate Past Chief of Staff shall remain vacant until a new Chief of Staff is elected. Officers shall serve through the last day of the Medical Staff Year. Newly elected officers will begin their terms on the first day of the next Medical Staff Year.

D. Staggering of Terms

In order to provide continuing and overlap of Medical Staff leadership, nominations and elections shall continue to be staggered such that the Chief of Staff and one Elected Representative, the Vice Chief of Staff and one Elected Representative, and the Secretary and one Elected Representative are elected in successive years, with the exception of elections to fill vacated offices pursuant to Article III, Part B, Section 4(D) below, and with no officer's term exceeding three years.

Section 4. Vacancies

Vacancies in office will be filled in the following manner:

A. The Chief of Staff will be replaced by the Vice Chief of Staff, who will serve as Chief of Staff. Should the Vice Chief of Staff decline or be unable to serve, the Secretary shall serve as Chief of Staff. Should the Secretary decline or be unable to serve, the Elected Representatives, in the order of their seniority, shall serve as Chief of Staff. The person succeeding to the office of Chief of Staff shall serve until the end of the term of such person's predecessor.

B. The Vice Chief of Staff shall be replaced by the Secretary, who shall

serve as Vice Chief of Staff. Should the Secretary decline or be unable to serve, the Elected Representatives, in the order of their seniority, shall serve as Vice Chief of Staff. The person succeeding to the office of Vice Chief of Staff shall serve until the end of the term of such person's predecessor's.

C. The Secretary shall be replaced by the Elected Representatives, in the order of their seniority. The person succeeding the office of Secretary shall serve until the end of the term of such person's predecessor.

D. Vacancies in the offices of Chief of Staff, Vice Chief of Staff, and Secretary which cannot be filled in accordance with Article III, Part B, Sections 4(A), (B), or (C) above, and vacancies in the office of Elected Representative, will be filled by appointment by the Nominations and Elections Committee, which appointment shall expire at the end of the Medical Staff Year in which such vacancy occurs.

E. If a vacancy is filled in accordance with Article III, Part B, Section 4(D) above, the office in which the vacancy occurred shall be subject to nomination at the next Annual Meeting following the date the vacancy occurred (except as stated in Section 4(F) below) and election following such Annual Meeting in accordance with Article III, Part B, Section 3(A) and (B), with the newly elected officer to complete the term of such person's predecessor.

F. If a vacancy in the office of Vice Chief of Staff, Secretary, or Elected Representative occurs during an Election Period in which such office is subject to election, the provisions of Article III, Part B, Section 4(D) above shall not apply, and the winning candidate in the election being held during such Election Period shall assume office as provided in Article III, Part B, Section 3(C) above.

G. Vacancy in the office of Immediate Past Chief of Staff shall not require replacement.

Section 5. Removal of an Officer of the Medical Staff

A. Grounds for Removal

1. Any officer of the Medical Staff shall immediately forfeit their office as provided in Article III, Part B, Section 1 above if they cease, for any reason, to be members of the Active staff.

2. Any officer of the Medical Staff may be removed from office on one or more of the following grounds:

a. Failure or inability for any reason, including physical or

mental infirmity, to fulfill the duties of their particular office as listed in Article III, Part B, Section 2 above;

b. Conduct detrimental to the interests of the University of Kansas Hospital.

B. Procedure for Removal

1. Automatic removals pursuant to Article III, Part B, Section 5(A)(1) above shall be effective immediately and shall not require a meeting or vote of the Medical Staff.

2. Removal other than automatic removals pursuant to Article III, Part B, Section 5(A)(1) above may only be accomplished at a Special Meeting of the Medical Staff called for that purpose and at which a quorum is present.

a. The officer whose removal is sought may be removed from office by a vote of a majority of the members of the Active staff present at such meeting.

b. The Special Meeting to consider the removal of any officer shall be called by the Chief of Staff, or the Vice Chief of Staff if the Chief of Staff is the officer whose removal is sought, upon written request of the Board, the Executive Committee, or at least ten percent (10%) of the members of the Active staff. Said written request shall be delivered to the Chief of Staff or to the Vice Chief of Staff if the Chief of Staff is the officer whose removal is sought. Said Special Meeting shall be held no earlier than ten (10) and no later than twenty (20) days following the Chief of Staff's or Vice Chief of Staff's receipt of such a written request.

c. The Chief of Staff or Vice Chief of Staff shall send notice of such a Special Meeting to all Medical Staff members no later than three (3) days prior to the date of said Special Meeting, which notice shall state the date and time of the Special Meeting and the purpose for which it is to be held.

d. The officer whose removal is sought shall be afforded a reasonable opportunity to address the Special Meeting prior to any vote on such officer's removal.

PART C: MEETINGS OF THE MEDICAL STAFF

Section 1. Annual Meeting

The Medical Staff shall hold its annual meeting ("Annual Meeting") at least sixty

(60) days before the end of the Medical Staff Year. The Chief of Staff shall cause a written notice specifying the date, time and place of the Annual Meeting to be delivered to each member of the Medical Staff at least ten (10) days in advance of such meeting. The purpose of the Annual Meeting shall be to report on the activities of the Medical Staff, to nominate candidates for election as officers of the Medical Staff, to nominate and elect members of the Nominations and Elections Committee, and to transact such other business as may be necessary and desirable. The Secretary of the Medical Staff shall prepare written minutes of each Annual Meeting.

Section 2. Special Staff Meetings

Special meetings of the Medical Staff ("Special Meetings") may be called at any time (i) by the Chief of Staff, (ii) upon request of the Board or the Executive Committee, or (iii) upon the written request of at least ten percent (10%) of the members of the Active staff, which request or petition shall state the purpose of such meeting. The Chief of Staff shall schedule any such Special Meeting no less than ten (10) and no more than twenty (20) days following the Chief of Staff's receipt of such a request and shall notify all members of the Medical Staff of the time, place and purpose of such Special Meeting no later than three (3) days prior to such Special Meeting.

Section 3. Quorum

Quorum requirement for any Annual or Special Meeting is defined as those Medical Staff members present. In the event that a vote is required regarding the removal of an officer, a majority of the Active staff must be present.

Section 4. Executive Committee Reports

All policy decisions of the Executive Committee shall be included in the Executive Committee's report to the Medical Staff at all Annual Meetings and any Special Meetings called for the purpose of receiving or demanding a report from the Executive Committee. At any Annual Meeting, or at any Special Meeting called for that purpose, the Medical Staff may, by majority vote, require the Executive Committee to reconsider any such policy decision at the Executive Committee's next meeting. In the event that such reconsideration does not result in a policy decision which is approved by the Medical Staff at or before the next Annual Meeting, the Medical Staff may, at such Annual Meeting or at any subsequent Special Meeting called for that purpose, approve an appropriate policy by majority vote.

Section 5. Rules of Order

Whenever its provisions do not conflict with these Bylaws, Sturgis Standard Code of Parliamentary Procedure, shall govern all meetings.

ARTICLE IV: CLINICAL SERVICES OF THE MEDICAL STAFF

PART A: CLINICAL SERVICES

Section 1. Organization

The Medical Staff shall be organized into the following Clinical Services:

Anesthesiology
Cardiovascular Diseases
Emergency Medicine
Family Medicine
Internal Medicine
Neurology
Neurosurgery
Obstetrics and Gynecology
Ophthalmology
Orthopedics
Otorhinolaryngology
Pathology and Laboratory Medicine
Pediatrics
Plastic Surgery
Psychiatry and Behavioral Sciences
Radiology
Radiation Oncology
Rehabilitation Medicine
Surgery
Urology

Section 2. Assignment

Each person appointed to the Medical Staff shall be assigned to the Clinical Service(s) appropriate to their medical specialty and the clinical privileges they have been granted.

Section 3. Changes

When deemed appropriate, the Medical Staff and the Board, by their joint action, may add, delete, combine or sub-divide Clinical Services.

PART B: CLINICAL SERVICE CHIEFS

Section 1. Clinical Service Chief

The designation of "Clinical Service Chief" refers to the physician's administrative role within the Hospital's governance and operational structure as a member of the Medical Staff and related to Hospital's inpatient and outpatient clinical activities (this does not include non-Hospital clinical activities, such as Kansas University Physicians, Inc. ("KUPI") clinics, etc.). Clinical Service Chiefs report to the CEO of the Hospital; provided, however,

that Clinical Service Chiefs are required to regularly communicate with and advise the Dean regarding material clinical issues that could possibly affect the Medical School's academic mission. To qualify as a Clinical Service Chief a physician must be certified by the appropriate specialty board for his or her respective Clinical Service or have affirmatively established comparable competence through the credentialing process.

Section 2. Department Chair

The designation of "Department Chair" refers to the physician's administrative leadership role within the Medical School's governance and operational structure as a member of the faculty of the Medical School. Department Chairs report to the Dean; provided, however, that Department Chairs are required to regularly communicate with and advise the CEO of the Hospital regarding material research, educational and non-Hospital patient issues that could possibly affect the Hospital's clinical mission.

Section 3. Appointment of a Clinical Service Chief

A. Except as otherwise provided in Article IV, Part B, Section 3(B) below, the Department Chair of each clinical department of the Medical School shall be the Clinical Service Chief of the corresponding Clinical Service of the Hospital. Notwithstanding anything to the contrary in this Article IV, the CEO of the Hospital shall, in consultation with the Dean, appoint the Clinical Service Chief when there is no corresponding clinical department of the Medical School.

B. The Department Chair shall not serve as the Clinical Service Chief if:

1. The Department Chair voluntarily chooses not to serve in the capacity of Clinical Service Chief;

2. The Department Chair is not, or does not, become a member of the Medical Staff; or

3. The Dean and the CEO of the Hospital have mutually agreed that the Department Chair will not serve as the Clinical Service Chief.

C. In the event that the Department Chair will not be the Clinical Service Chief pursuant to Article IV, Part B, Section 3(B) above, the CEO of the Hospital, after consultation with the Department Chair and the President of KUPI, shall appoint a KUPI physician from the applicable clinical department of the Medical School (unless a suitable candidate is not available) who is a member of the Medical Staff to serve as the Clinical Service Chief; provided, however, that the CEO of the Hospital may select a Hospital-employed cardiologist or a Hospital-employed cardiothoracic surgeon who is a member of the Medical Staff to be the Clinical Service Chief for the Cardiovascular Diseases Clinical Service. The appointee shall be subject to approval by the Dean; provided, however, that if the Dean does not approve the

appointment, the CEO of the Hospital can appeal the Dean's decision to the Hospital Authority Board, and such Board decision shall be final, binding and unappealable.

D. Notwithstanding any other provision in these Bylaws to the contrary, and irrespective of his or her category of appointment, a Clinical Service Chief shall be entitled to vote on matters presented at general and special meetings of the Medical Staff, hold office, serve as a voting member on Medical Staff committees to which he or she is appointed or elected, and serve as a chairperson of such committees.

Section 4. Clinical Service Chief Duties. Each Clinical Service Chief shall:

A. Serve as a member of the Executive Committee.

B. Assume responsibility for the implementation within the Clinical Service of actions taken by the Board and Executive Committee.

C. Assume responsibility for enforcement within the Clinical Service of the Bylaws of the Medical Staff, Rules and Regulations of the Medical Staff, policies and procedures of the Medical Staff and Hospital, and the Bylaws of the Hospital Authority.

D. Transmit to the Executive Committee recommendations, including recommendations of the Department Chair (as applicable), concerning the appointment, reappointment and delineation of clinical privileges for all individuals in and applications to his/her Clinical Service.

E. Monitor all clinically related activities of the Clinical Service and all members of the Medical Staff assigned to the Clinical Service with delineated privileges.

F. Monitor all admission-related activities of the Clinical Service.

G. Integrate the Clinical Service into the primary functions of the Hospital.

H. Assume responsibility for the Clinical Service's establishment of written criteria for the assignment of clinical privileges to Medical Staff members assigned to such Clinical Service. Such criteria shall be approved by the Executive Committee and the Board and may be amended from time to time upon the approval of the Executive Committee and the Board.

I. Assume responsibility for the Clinical Service's development and implementation of policies and procedures that guide and support the provision of care, treatment and services.

J. Assume responsibility for the Clinical Service's continual assessment and improvement of the quality of care, treatment and services within the Clinical Service.

K. Assume responsibility for the Clinical Service's maintenance of quality control and improvement programs.

L. Assume responsibility for the Clinical Service's orientation and continuing education for Hospital related activities.

M. Recommend a sufficient number of qualified and competent persons to provide care, treatment and services for the Clinical Service.

N. Regularly communicate with and advise the Dean regarding material clinical issues that could possibly affect the Medical School's academic mission.

O. If the Clinical Service Chief is not the Department Chair, report to the Department Chair as defined by departmental organizational structure.

P. Assume responsibility for administrative activities of the Clinical Service, unless otherwise provided by the Hospital.

Q. Assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment and services not provided by the Clinical Service or the Hospital.

R. Coordinate and integrate services between, among and within the Clinical Services.

S. Determine the qualifications and competence of the Clinical Service personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

T. Recommend space and other resources needed by the Clinical Service.

Section 5. Removal of a Clinical Service Chief

A. A Clinical Service Chief who is also the Department Chair shall serve until such person voluntarily steps down from the position of Clinical Service Chief (in which case the new Clinical Service Chief shall be appointed pursuant to Article IV, Part B, Section 3(C) above), such person is replaced by the Dean as the Department Chair (in which case the new Department Chair will become the new Clinical Service Chief unless one of the conditions in Article IV, Part B, Section 3(B) above applies (in which case the new Clinical Service Chief will be appointed pursuant to Article IV, Part B, Section 3(C) above), or such person is removed pursuant to Article IV, Part B, Section 5(B) below (in which case the replacement Clinical Service Chief will be determined pursuant to Article IV, Part B, Section 6 below).

A Clinical Service Chief who is not also the Department Chair shall serve until (1) such person voluntarily steps down from position of Clinical Service Chief (in which case the new Clinical Service Chief shall be appointed pursuant to Article IV, Part B, Section 3(A) above); (2) such person is removed pursuant to Article IV, Part B, Section 5(B) below (in which case the replacement Clinical Service Chief will be determined pursuant to Article IV, Part B, Section 3(C) above); or (3) the Department Chair requests the removal of the Clinical Service Chief and at least two out of the three following persons concur with the removal decision: the CEO of the Hospital, the Dean, and the President of KUPI; provided, however, that if one of those three persons does not consent to the removal, that person(s) can appeal the decision of the Department Chair and the other two persons to the Hospital Authority Board, and such Board decision on removal shall be final, binding and unappealable (in which case the replacement Clinical Service Chief will be determined pursuant to Article IV, Part B, Section 3(C)).

B. The CEO of the Hospital may remove any Clinical Service Chief (including a Clinical Service Chief also serving as a Department Chair) under any of the following conditions:

1. upon mutual agreement of the CEO of the Hospital, the Dean and the President of KUPI; or

2. for "Cause" (as defined in Article IV, Part B, Section 5(C) below), after consultation with the Dean and the President of KUPI; or

3. the Clinical Service Chief receives an "unsatisfactory" annual evaluation by the CEO of the Hospital (which evaluation must specify in writing the Clinical Service Chief's performance deficiencies and must be performed pursuant to an evaluation process mutually agreed to by the Dean, the President of KUPI and the Medical Staff Executive Committee), and the Clinical Service Chief has not cured the specified performance deficiencies, within ninety (90) days of such written notice, to the CEO of the Hospital's reasonable satisfaction and either (a) the Dean and the President of KUPI agree to such termination, or (b) two-thirds of all members of the Executive Committee affirmatively vote to terminate the Clinical Service Chief. If the CEO of the Hospital cannot obtain the support described in either (a) or (b), the CEO of the Hospital can invoke the Dispute Resolution Process described in the Section 9.03 of the Affiliation Agreement between the Hospital, the University and KUPI effective December 31, 2007.

Any Clinical Service Chief so removed may remain a Department Chair at the discretion of the Dean.

C. For purposes of Article IV, Part B, Section 5(B)(2) above, "Cause" means any of the following:

1. Suspension for more than thirty (30) days or revocation of the Clinical Service Chief's license to practice medicine or voluntary surrender of the Clinical Service Chief's license to practice medicine in connection with any proceeding that could result in disciplinary action against the Clinical Service Chief;

2. Failure of the Clinical Service Chief to obtain or maintain board certification;

3. Suspension for more than thirty (30) days or revocation of the Clinical Service Chief's Medical Staff membership or voluntary surrender of the Clinical Service Chief's Medical Staff membership in connection with any proceeding that could result in disciplinary action against the Clinical Service Chief;

4. Entry of a judgment by a court of competent jurisdiction that the Clinical Service Chief is not legally competent;

5. The Clinical Service Chief's conviction of, or plea of nolo contendere to, any felony or to a misdemeanor involving moral turpitude;

6. The Clinical Service Chief's continued willful misconduct, insubordination, or disruptive behavior, or the Clinical Service Chief's theft of Hospital property;

7. The reasonable determination that the Clinical Service Chief's treatment of patients is grossly negligent or otherwise egregiously below or outside acceptable standards of care; or

8. The Clinical Service Chief's inability, due to illness or injury (whether mental or physical) and notwithstanding reasonable accommodation, to perform the essential functions of the Clinical Service Chief's position for a period of one hundred eighty (180) consecutive days or for two hundred (200) days within any three hundred sixty-five (365) day period.

Section 6. Appointment of a Replacement Clinical Service Chief

If a Clinical Service Chief is removed pursuant to Article IV, Part B, Section 5(B) above but remains the Department Chair at the Dean's discretion, the CEO of the Hospital (after consultation with the Dean and the President of KUPI) shall select a KUPI physician from the applicable clinical department of the Medical School (unless a suitable candidate is not available) who is a member of the Medical Staff to serve as the replacement Clinical Service Chief; provided, however, that the CEO of the Hospital may select a Hospital-employed cardiologist or a Hospital-employed cardiothoracic surgeon who is a member of

the Medical Staff to be the Clinical Service Chief for the Cardiovascular Diseases Clinical Service.

If (1) there is a change of the Department Chair and such person is also serving as Clinical Service Chief, or (2) the Clinical Service Chief is removed pursuant to Article IV, Part B, Section 5(B) above and the Dean also desires to remove them as Department Chair, then the Dean's replacement as Department Chair shall also become the Clinical Service Chief unless otherwise provided in Article IV, Part B, Section 3(B) above, in which case the appointment of the Clinical Service Chief will be pursuant to Article IV, Part B, Section 3(C) above.

If a person is serving as Clinical Service Chief because the Department Chair voluntarily chooses not to serve in that capacity (pursuant to Article IV, Part B, Section 3(B)(1)), and the Department Chair is subsequently replaced, the new Department Chair can either (1) serve as the new Clinical Service Chief, or (2) appoint another person to serve as the Clinical Service Chief if at least two out of the three following persons concur with the appointment decision: the CEO of the Hospital, the Dean, and the President of KUPI; provided, however, that if one of those three persons does not consent to the appointment, that person can appeal the decision of the Department Chair and the other two persons to the Hospital Authority Board. The Hospital Authority Board will either appoint the candidate supported by the appealing person or the candidate supported by the Department Chair and the other two persons. The appointment decision of the Hospital Authority Board shall be final, binding and unappealable.

ARTICLE V: STANDING COMMITTEES OF THE MEDICAL STAFF

PART A: EXECUTIVE COMMITTEE

Section 1. Composition

A. The Executive Committee shall consist of the officers of the Medical Staff and the Clinical Service Chiefs of the Clinical Services listed in Article IV, Part A. The CEO of the Hospital shall be an ex officio, voting member of the Executive Committee. The Dean shall be an ex officio, nonvoting member of the Executive Committee.

B. The Chief of Staff shall be the chair of the Executive Committee.

C. Because the Executive Committee consists of the officers of the Medical Staff, the Clinical Service Chiefs, the CEO of the Hospital and the Dean, each such member of the Executive Committee shall be elected/appointed and removed from the Executive Committee in the same manner such member is elected/appointed to his or her respective titled position.

Section 2. Meetings

A. A quorum for any meeting of the Executive Committee shall be defined as those members of the Executive Committee present.

B. Members of the Executive Committee shall be present at no fewer than fifty percent (50%) of the meetings of the Executive Committee during any Medical Staff Year. If a member of the Executive Committee is present at fewer than fifty percent (50%) of the meetings of the Executive Committee during any Medical Staff Year, said member shall be removed from office, if an officer of the Medical Staff, or removed from the Executive Committee, if a Clinical Service Chief.

C. Members of the Executive Committee whose membership is by virtue of their status as Clinical Service Chief may, by written notice to the Executive Committee, designate any member of the Active staff assigned to said member's Clinical Service to attend any meeting of the Executive Committee and vote in said member's stead, and such designee shall count toward the attendance requirement of Article V, Part A, Section 2(B) above.

D. All other procedures governing meetings of the Executive Committee shall be those found in the Medical Staff Committee Procedures.

Section 3. Duties

The duties of the Executive Committee shall be:

A. To represent and to act on behalf of the Medical Staff in all matters between meetings of the Medical Staff, subject to any limitations imposed by these Bylaws;

B. To coordinate the activities and general policies of the Medical Staff;

C. To receive and act upon committee reports and to make recommendations concerning them to the Medical Staff;

D. To implement policies of the Medical Staff not otherwise the responsibility of the Clinical Services;

E. To provide liaison among the Medical Staff, the CEO of the Hospital, and the Board;

F. To make recommendations to the CEO of the Hospital and to the Board on Medical Staff matters;

G. To ensure that the Medical Staff is kept abreast of, and facilitates compliance with, the requirements of hospital accreditation as established by The Joint Commission and informed of the accreditation status of the Hospital;

H. To ensure the Medical Staff's accountability to the Hospital for the medical

care of patients in the Hospital;

I. To make recommendations to the Board for appointment and reappointment to the Medical Staff, departmental assignments, delineation of clinical privileges, and corrective action in accordance with these Bylaws;

J. To take all reasonable steps to ensure professionally ethical conduct and competent performance by all members of the Medical Staff;

K. To conduct such other functions as are necessary for the effective operation of the Medical Staff; and

L. To report its activities and policy decisions at each Annual Meeting or any Special Meeting called for such purpose.

Section 4. The Executive Committee shall report its activities to the Board. The Chief of Staff and such members of the committee as are deemed necessary shall be available to meet with the Board or its applicable committees on all recommendations that the Executive Committee or Chief of Staff may make.

Section 5. Between meetings of the Executive Committee, the Chief of Staff shall be empowered to act in situations of urgent and/or confidential nature where not prohibited by these Bylaws. The Chief of Staff shall report any such actions to the next Executive Committee meeting.

Section 6. In addition to those duties and responsibilities of the Executive Committee set forth herein, the Medical Staff may delegate the Executive Committee to act on the Medical Staff's behalf on certain matters by a two-thirds (2/3) vote of the members of the Active staff. The members of the Active staff may also remove the Executive Committee's delegated authority upon a two-thirds (2/3) vote.

PART B: NOMINATIONS AND ELECTIONS COMMITTEE

Section 1. Composition

The Nominations and Elections Committee shall consist of five (5) members of the Active staff, who are not Clinical Service Chiefs, who are not currently elected as officers of the Medical Staff and who are nominated and elected at each Annual Meeting of the Medical Staff. The Nominations and Elections Committee will choose its own chair. Members of the Nominations and Elections Committee will serve one year without eligibility for re-election for the three-year period following the expiration of their term.

Section 2. Duties

A. The duties of the committee will be to nominate a slate of candidates, to supervise the election of officers, and to fill vacancies in offices in accordance with

Article III, Part B, Section 4(D).

B. Nominations and elections of candidates shall be governed by the following provisions:

1. Slates of candidates will be chosen only for those offices vacant after the end of the current Medical Staff year and for those offices to be filled in accordance with Article III, Part B, Section 4(E).

2. At least one nominee for each Medical Staff office position to be elected will be presented to the Annual Meeting. Nominees shall meet all of the qualifications of officers of the Medical Staff and shall have previously indicated to the committee that they are willing to serve in the office for which they are nominated.

3. The committee will conduct the balloting for election of officers in accordance with Article III, Part B, Section 3.

PART C: OTHER COMMITTEES

Other committees, whether standing or ad hoc, shall be those established pursuant to the Medical Staff Committee Procedures, as adopted and amended by the Executive Committee with the approval of the Board, and shall have those responsibilities, limitations and procedures as established pursuant to the Medical Staff Committee Procedures.

ARTICLE VI: APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF

PART A: QUALIFICATIONS AND CONDITIONS

Section 1. Appointment and reappointment to the Medical Staff is a privilege which shall be extended only to professionally competent physicians and dentists who continuously meet the qualifications, standards and requirements set forth in these Bylaws. All persons practicing medicine and dentistry in the Hospital, unless excepted by specific provisions of these Bylaws, must first have been appointed to the faculty of the Medical School and to the Medical Staff.

Section 2. Only physicians and dentists currently licensed to practice in the State of Kansas who can document required continuing medical education, their background, experience, successful completion of residency, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation and character and their ability to work harmoniously with others sufficiently to convince the Executive Committee that all patients treated by them in the Hospital will receive a high quality of medical care and that the Hospital and Medical Staff will be able to operate in an orderly manner shall be qualified for appointment and reappointment to the Medical Staff. The word "character" is intended to include the applicant's mental and emotional stability.

Section 3. No physician or dentist shall be entitled to appointment or reappointment to the

Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that such physician or dentist is a member of the faculty of the Medical School, is duly licensed to practice medicine or dentistry in Kansas or any other state, is a member of any particular professional organization, or had in the past, or currently has, medical staff appointment or privileges at another hospital.

Section 4. No physician or dentist shall be denied appointment or reappointment on the basis of sex, race, creed, color, or national origin.

Section 5. Acceptance of appointment or reappointment to the Medical Staff shall constitute an agreement of the physician or dentist that such physician or dentist will abide by the particular code or codes of professional ethics of the American Medical Association, the American Osteopathic Association or the American Dental Association, whichever is applicable.

Section 6. In addition to any notification requirements set forth in this Article VI, the applicant/member must promptly notify the Chief of Staff (or, if the member at issue is the Chief of Staff, to the Vice Chief of Staff), in writing, of any change, modification or update to information provided by such applicant/member in the initial application for appointment to the Medical Staff or subsequent applications for reappointment to the Medical Staff. The Chief of Staff (or, as applicable, the Vice Chief of Staff) shall forward the information to the Credentialing Committee or the Medical Staff Health Advisory Committee, as applicable.

Section 7. Acceptance of appointment or reappointment to the Medical Staff shall constitute the agreement of the physician or dentist that they will promptly notify the Clinical Service Chief of the Clinical Service to which such physician or dentist is assigned and the Chief of Staff, in writing, of the revocation or suspension of such physician's or dentist's professional license in any state, or the imposition of terms of probation or limitation of practice by any state or other governmental body or unit, or of such physician's or dentist's loss of staff membership or loss or restriction of privileges at any hospital or other health care institution, or of receipt of notice of any formal charges or the commencement of a formal investigation by any professional regulatory or licensing agency or the filing of charges by the Department of Health and Human Services, peer review organizations, or any law enforcement agency or health regulatory agency of the United States or the State of Kansas, the filing of a claim against such physician or dentist alleging professional liability, or any change in or termination of the physician's or dentist's professional liability insurance required by these Bylaws and/or the Credentialing Procedures.

Section 8. Appointment and reappointment to the Medical Staff shall confer on the member only such clinical privileges as have been granted by the Board and shall require that each member assume such reasonable duties and responsibilities as the Board and the Medical Staff shall require.

Section 9. As part of the appointment and reappointment process, the physician or dentist must provide evidence to the Credentialing Committee of the current existence and extent of professional liability insurance coverage (minimums of $1,000,000 per occurrence, $3,000,000 aggregate), including the insurance carrier's name and address, and the inclusive dates of coverage. Acceptance of appointment or reappointment to the Medical Staff shall constitute the agreement of the physician or dentist to maintain professional liability insurance coverage (minimums of $1,000,000 per

occurrence, $3,000,000 aggregate), and to promptly notify the Clinical Service Chief of the Clinical Service to which such physician or dentist is assigned and the Chief of Staff or Vice Chief of Staff, in writing, of any changes to, and revocation or suspension of, such professional liability insurance coverage.

Section 10. As part of the appointment and reappointment process, the Chief of Staff or his or her designee shall obtain a current National Practitioner Data Bank report on the applicant.

PART B: APPOINTMENT

Section 1. Provisional Status

All initial appointments to the medical staff shall be considered provisional for a period of at least one (1) year following the effective date of appointment. During such period of provisional status, the member shall be permitted to admit patients* to the Hospital and to serve on committees but shall not exercise any other prerogative of the member's category of Medical Staff membership. At or near the conclusion of the member's provisional appointment, the member's performance while on provisional status shall be reviewed, and a final decision on the member's appointment shall be made in accordance with the Credentialing Procedures of the Medical Staff as they may be established and amended by the Executive Committee with approval of the Board. **See Page 1, PROVISIONAL*

Section 2. Procedure for Appointment

A. The procedure for appointment to the Medical Staff shall be that described in the Credentialing Procedures of the Medical Staff as they may be established and amended by the Executive Committee with the approval of the Board.

B. The applicant shall have the burden of producing adequate information for a proper evaluation of such applicant's competence, character, ethics, and other qualifications and of resolving any doubts about such qualifications. The applicant shall have the burden of providing evidence, if challenged, that all of the statements made and the information given on such applicant's application are factual and true. Except as otherwise determined by the Executive Committee, all initial appointments to the Medical Staff shall be subject to a period of Focused Professional Practice Evaluation ("FPPE") in accordance with the Focused Professional Practice Evaluation for Granting Privileges Medical Staff Policy (the "FPPE Policy"). For applicants for initial appointment to the Medical Staff, FPPE should be used when an applicant has the credentials to suggest competence, but the applicant is an initial appointee to the Medical Staff and a period of evaluation is needed to confirm competence in the Hospital's setting. If an applicant refuses to participate in the FPPE or fails to successfully complete an FPPE in accordance with the FPPE Policy, such applicant's privileges subject to the FPPE shall automatically be revoked and the applicant may request a Fair Hearing in accordance with Article VIII. Such applicant's privileges shall remain revoked until such time as the applicant successfully completes the FPPE process or such revoked privileges are reinstated

following a Fair Hearing in accordance with Article VIII.

C. In addition to any notification requirements set forth in this Article VI, the applicant/member must promptly notify the Chief of Staff (or, if the member at issue is the Chief of Staff, to the Vice Chief of Staff), in writing, of any change, modification or update to information provided by such applicant/member in the initial application for appointment to the Medical Staff. The Chief of Staff (or, as applicable, the Vice Chief of Staff) shall forward the information to the Credentialing Committee or the Medical Staff Health Advisory Committee, as applicable.

PART C: REAPPOINTMENT

Section 1. When Required

Reappointment to the Medical Staff shall be required on at least a biennial basis.

Section 2. Factors to be Considered for Reappointment

Each recommendation concerning reappointment of a member to the Medical Staff shall be based upon:

A. The member's professional ethics, competence, and clinical judgment in the treatment of patients as indicated by quality and risk management information related to such member's treatment of patients within the hospital, information obtained from other hospitals, health care facilities, and health plans, and updated information with respect to such member's professional liability experience.

B. The member's physical and mental capacity to treat patients.

C. The member's compliance with the Bylaws of the Hospital Authority, Hospital standard practices, and Medical Staff Bylaws, Rules, Regulations and policies and procedures.

D. The member's use of the Hospital's facilities for such member's patients, such member's cooperation and relations with other practitioners and such member's general attitude toward patients, the Hospital and the public.

Section 3. Procedure for Reappointment

A. The procedure for reappointment to the Medical Staff shall be that described in the Credentialing Procedures of the Medical Staff as they may be established and amended by the Executive Committee with the approval of the Board. Such procedure for reappointment to the Medical Staff may include a member's continual participation in Ongoing Professional Practice Evaluation ("OPPE") in accordance with the Medical Staff Peer Review Policy (the "OPPE Policy"). The use of OPPE

in making recommendations for reappointment shall be appropriate when questions arise regarding a member's ability to provide safe, high quality patient care. An applicant's failure to continually participate in OPPE or to comply with any resulting corrective action plan in accordance with the OPPE Policy shall result in the automatic revocation of such applicant's privileges subject to the OPPE Policy. Upon such revocation, the applicant may request a Fair Hearing in accordance with Article VIII. Such applicant's privileges shall remain revoked until such time as the applicant satisfactorily participates in the OPPE process or, as relevant, such revoked privileges are reinstated following a Fair Hearing in accordance with Article VIII.

B. The member applying for reappointment shall have the burden of providing adequate information for a proper evaluation of such member's competence, character, ethics, and other qualifications and of resolving any doubts about such qualifications. Such member shall have the burden of providing evidence, if challenged, that all of the statements made and the information given on such member's application are factual and true.

C. In addition to any notification requirements set forth in this Article VI, the member must promptly notify the Chief of Staff (or, if the member at issue is the Chief of Staff, to the Vice Chief of Staff), in writing, of any change, modification or update to information provided by such member in the application for reappointment to the Medical Staff. The Chief of Staff (or, as applicable, the Vice Chief of Staff) shall forward the information to the Credentialing Committee or the Medical Staff Health Advisory Committee, as applicable.

PART D: CLINICAL PRIVILEGES

Section 1. Delineation and Scope

A. Medical Staff appointment or reappointment shall not automatically confer any clinical privileges or right to practice in the Hospital. Each physician or dentist who has been given an appointment to the Medical Staff of the Hospital shall be entitled to exercise only those clinical privileges specifically recommended by the Medical Staff and approved by the Board.

B. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, references and other relevant information.

C. Surgical procedures performed by dentists shall be under the overall supervision of the Clinical Service Chief of the Clinical Service to which they have been assigned or such Clinical Service Chief's designee. A medical history and physical examination of any patient upon whom a surgical procedure is to be performed by a dentist shall be made and recorded by a physician who is a member of the Medical Staff before the surgery is performed, and a designated physician who is a member of the Medical Staff shall be responsible for the diagnosis and

management of the medical problems of any such patient which may be present or arise during the period of hospitalization.

Section 2. Procedure for Assignment of Clinical Privileges

A. The procedure for assignment of clinical privileges shall be that described in the Credentialing Procedures of the Medical Staff as they are established and amended by the Executive Committee with the approval of the Board.

B. The member applying for reappointment shall have the burden of providing sufficient evidence to support such member's qualifications and competence to exercise any clinical privileges such member's requests.

PART E: MODIFICATION OF CLINICAL PRIVILEGES

Section 1. Qualifications

Any member of the Medical Staff who wishes to augment or otherwise modify such member's clinical privileges may be granted such augmentation or modification upon such member's demonstration that such member possesses the requisite training, skill, and experience necessary to competently exercise the clinical privileges sought.

Section 2. Procedure for Modification of Clinical Privileges

A. The procedure for modification of clinical privileges shall be that described in the Credentialing Procedures of the Medical Staff as they are established and amended by the Executive Committee with the approval of the Board. Such procedures for modification of clinical privileges may include the use of FPPE in accordance with the FPPE Policy.

B. The member shall have the burden of providing sufficient evidence to support such member's qualifications and competence to exercise any additional clinical privileges such member requests.

C. As part of the procedure for augmentation of clinical privileges, the Chief of Staff or his or her designee shall obtain a current National Practitioner Data Bank report on the member.

PART F: EMERGENCY CLINICAL PRIVILEGES

In an emergency, any physician or dentist who is not a member of the Medical Staff, to the degree permitted by such physician's or dentist's license and regardless of clinical privileges, may be permitted to do, and shall be assisted in doing, everything possible to save the life of a patient in the Hospital, using every facility of the Hospital necessary, including calling for any consultation necessary or desirable. When the emergency situation no longer exists, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is

defined as a condition which could result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and in which any delay in administering treatment would add to that danger.

PART G: LIMITED PRIVILEGE PRACTITIONER

At the invitation of a member, limited clinical privileges 1) to care for a specific patient, with the duration of the temporary privileges limited to the period of that patient's stay in the Hospital; or 2) for specific clinical services, with the duration of the limited privileges to be specified in advance and limited only to the period necessary to render such clinical services, may be requested by a practitioner who is not a member of the Medical Staff. In no event shall limited clinical privileges granted a limited privilege practitioner exceed sixty (60) days per each request. Notwithstanding the foregoing, a practitioner's limited clinical privileges may be renewed for one additional sixty (60) day period at the end of the initial sixty (60) day period, upon the practitioner's written request to the Chief of Staff and the CEO of the Hospital; provided that such practitioner's circumstances have not materially changed since the limited clinical privileges were granted. However, in no event may a practitioner's limited privileges exceed one hundred twenty (120) days per request. The procedure for granting such limited privileges is outlined in the Credentialing Procedures of the Medical Staff.

PART H: TEMPORARY CLINICAL PRIVILEGES

Section 1. Temporary clinical privileges may be granted to certain applicants who strictly meet the following criteria:

A. The applicant's application for clinical privileges is complete, has been completely processed in accordance with the Credentialing Procedures of the Medical Staff, and is awaiting action by the Executive Committee or any Credentialing Committee;

B. Neither the applicant's application, the materials submitted in support thereof, nor the information generated by the processing of the application and supporting materials pursuant to the Credentialing Procedures of the Medical Staff contains any discrepancy or any information that would require further investigation before the application is approved; and

C. The Hospital has an immediate need for the applicant's services in order to render care to patients who cannot reasonably be cared for at the Hospital by any other physician.

Section 2. All applicants granted temporary clinical privileges shall be subject to the supervision of the Chief of Staff or the Chief of Staff's designee and shall submit to any personal supervision and/or proctoring deemed necessary by the Chief of Staff, the CEO of the Hospital, or the Board.

Section 3. Temporary clinical privileges shall be granted for a maximum period of sixty (60) days or until the applicant's application is approved by the Executive Committee,

whichever period is shorter, and shall expire automatically at the end of said period. During such period, the applicant shall have the same prerogatives as members of the Provisional Staff.

Section 4. The procedure for granting, modifying, suspending, or revoking temporary clinical privileges shall be that stated in the Credentialing Procedures of the Medical Staff.

PART I: DISASTER PRIVILEGES

In the event of a disaster causing the activation of the Hospital's Emergency Management Plan and rendering the Hospital unable to handle immediate patient needs, clinical privileges may be granted to a practitioner who is not a member of the Medical Staff the necessary to render clinical services to handle immediate patient needs. The procedure for granting such disaster privileges is outlined in the Credentialing Procedures of the Medical Staff.

PART J: HISTORY AND PHYSICAL EXAMINATION

Section 1. A history and physical examination must be dictated or documented in the electronic medical record by the patient's attending physician, a Member of the House Staff, a credentialed Advanced Registered Nurse Practitioner (ARNP) or a Physician Assistant (PA), all under the attending physician's supervision. The history and physical must be available in the patient medical record on all inpatients within twenty-four (24) hours of admission and on all patients prior to surgery or procedure. The history and physical examination shall be countersigned by the attending physician.

Section 2. The history and physical examination completed before admission is valid for thirty (30) days only, and must be updated with any changes (or state that no changes have occurred) within twenty-four (24) hours after admission, and prior to a surgery or procedure. The update must be documented in the electronic medical record. A history or physical examination greater than thirty (30) days old cannot be updated, or referred to, in a current history and physical examination.

ARTICLE VII: ACTIONS AFFECTING MEDICAL STAFF MEMBERS

PART A: MEDICAL STAFF HEALTH ADVISORY PROGRAM

Section 1. Medical Staff Health Advisory Program

The Hospital shall have in place a policy that describes the process for the recognition and reporting of health concerns of a member of the Medical Staff. The health concern may be either emotional or physical or both, and includes but is not limited to, members of the Medical Staff under emotional distress, and those under the influence of alcohol or other mood altering medications as well as deterioration through the aging process, disease process, or loss of motor skill, chemical or alcohol dependency, psychiatric dysfunction, any detrimental effects of aging, injury or condition, or any other medical condition which presents or may present a potential risk to patients or Hospital staff who

work with or see patients or has the potential of reducing the ability of the member to care for patients or effectively interact with Hospital staff.

Section 2. Goals

The goals of the policy are rehabilitation, rather than discipline, and assistance to the member of the Medical Staff in retaining or regaining optimal professional functioning, consistent with protection of patients. If, however, at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that the member of the Medical Staff is unable to safely perform the privileges he or she had been granted or that care provided by the member might subject the member to corrective action under these Bylaws, the matter shall be reported to the Executive Committee in accordance with Article VII, Part C below, for appropriate corrective action that may result in a mandated report to the applicable state or federal agency, association and/or to the Medical Advocacy Program of the Kansas Medical Society.

Section 3. Self-Reporting

All members of the Medical Staff are encouraged to self-report any health concern to the Medical Staff Health Advisory Committee or to the Chief of Staff for confidential referral of the member to the Medical Staff Health Advisory Committee.

Section 4. Third Party Reporting

A. All members of the Medical Staff and all employees of the Hospital and any other third party may report to the Medical Staff Health Advisory Committee any first-hand knowledge of any health concerns involving a member of a Medical Staff that does not impact or involve patient safety or the orderly operation of the Hospital. The identity of any individual making the report shall be kept confidential.

B. All members of the Medical Staff and all employees of the Hospital shall report, and any other third party may report, any first-hand knowledge of any health concerns involving a member of the Medical Staff that might constitute grounds for corrective action as specified in Article VII, Part C, Section 2 below or which impacts or involves patient safety or the orderly operation of the Hospital. Reports may be made to the Medical Staff Health Advisory Committee, the Clinical Service Chief of the affected member's Clinical Service, the CEO of the Hospital, the Chief of Staff (or the Vice Chief of Staff) or the employee's supervisor, who shall notify one of the aforementioned parties. Such reports shall be handled as a "Report" in accordance with Article VII, Part C, Section 3 below.

Section 5. Medical Staff Health Advisory Committee

The Committee Procedures of the Medical Staff sets forth the duties, composition and confidentiality requirements of the Medical Staff Health Advisory Committee.

PART B: COLLEGIAL INTERVENTION

Section 1. These Bylaws require each member to cooperate with the Hospital, the Board, Medical Staff officers, Clinical Service Chiefs, Executive Committee and other Medical Staff committees in order to continuously improve individual and collective performance. From time to time, these entities or persons may choose to hold routine discussions with a member or multiple members in order to provide education, assistance in providing quality medical care, and encouragement to participate in performance improvement, resource management, or other activities with the Hospital. The routine function of performance improvement, resource management or other programs, and the discussion among members in that context, does not constitute an investigation, corrective action, nor entitle members to Fair Hearing Rights or right to counsel pursuant to Article VIII.

Section 2. Members are expected to conform their conduct with the expectations set forth in these Bylaws, the Rules, and the Policies. Conduct which falls below such expectations may be addressed in accordance with the appropriate Rule or Policy and may be referred for corrective action in accordance with Article VII, Part C.

Section 3. These Bylaws encourage the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by a Member to resolve an issue that has been raised.

Section 4. Collegial intervention is a part of the Hospital's professional review and/or peer review activities and may include, but is not limited to, the following:

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

B. Proctoring, monitoring, consultation, and letters of guidance; and

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

Section 5. The relevant Medical Staff leader(s), in conjunction with the Chief of Staff, may determine whether a matter should be handled in accordance with another Policy (e.g., code of conduct policy, disruptive physician policy, peer review policy) or should be referred to the Executive Committee for further action pursuant to Article VII, Part C.

Section 6. The relevant Medical Staff leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in the member's confidential file. The member will have an opportunity to review the documentation and respond to it. The response will be maintained in the member's file along with the original documentation.

PART C: CORRECTIVE ACTIONS INVOLVING CLINICAL COMPETENCE,

PROFESSIONAL CONDUCT, AND OTHER INFRACTIONS

Section 1. Corrective Action Defined

Corrective action, as recommended by the Executive Committee and imposed by the Board may take any of the following forms:

A. Revocation of Medical Staff membership.

B. Suspension of Medical Staff membership for a definite term.

C. Revocation of all or a portion of the member's existing clinical privileges.

D. Suspension or limitation of the member's existing clinical privileges, including requiring proctoring or consultation, for a specified period of time.

E. A letter of reprimand to the member, a copy of which is placed in the member's permanent credentials file as maintained in accordance with these Bylaws.

Section 2. Grounds for Corrective Action

The following shall constitute grounds for corrective action against a member of the Medical Staff:

A. The member's clinical incompetence;

B. The member's care or treatment of a patient, or patients, or the member's management of the care of a patient or patients which falls below the applicable standard of care;

C. The member's violation of these Bylaws and/or Rules and Regulations, the Credentialing Procedures, the Committee Procedures or any other policies and procedures of the Medical Staff and/or the Bylaws or policies and procedures of the Hospital Authority;

D. The member's failure to comply with the ethics of such member's profession;

E. The member's behavior or conduct considered to be disruptive to the operation of the Hospital, the functioning of the Medical Staff, or the delivery of high quality medical care at the Hospital.

Section 3. Initiation of Corrective Action Proceedings

A. Reporting

1. All members of the Medical Staff, the CEO of the Hospital, any member of the Board, and all employees of the Hospital shall report, and any other person may report, any first-hand knowledge that any member of the

Medical Staff has engaged in any activity which may constitute grounds for corrective action as specified in Article VII, Part C, Section 2 above or which may otherwise raise concerns about the member's competence or professional conduct (the "Report").

2. All Reports shall be immediately forwarded to the Chief of Staff (or, if the Report involves the Chief of Staff, to the Vice Chief of Staff) and the Risk Manager of the Hospital.

3. The Chief of Staff or Vice Chief of Staff, as the case may be, shall review any Report forwarded to him or her and determine whether the Report suggests the reasonable possibility that the member has a physical or mental illness, injury, disorder, or condition that affects his or her ability to properly provide medical care to patients.

a. If the Chief of Staff or Vice Chief of Staff, as the case may be, determines in the affirmative, he or she shall immediately refer the Report to the Medical Staff Health Advisory Committee for further action in accordance with Article VII, Part C, Section 7 below.

b. If the Chief of Staff or Vice Chief of Staff, as the case may be, determines in the negative, he or she shall, within fifteen (15) days of receiving the Report, initiate collegial intervention as described in Article VII, Part B, or forward such Report to the Executive Committee for further action in accordance with Article VII, Part C, Section 8 below.

Section 4. Executive Committee Initiation

The Executive Committee may, on its own motion:

A. Determine that a member of the Medical Staff may have a physical or mental illness, injury, disorder, or condition that affects the member's ability to properly render medical care to patients. Upon making such determination, the Executive Committee shall immediately refer the matter to the Medical Staff Health Advisory Committee, which shall proceed in accordance with Article VII, Part C, Section 7 below.

B. Determine that corrective action against a member of the Medical Staff may be warranted and that an investigation into the matter which prompted such determination should proceed.

Section 5. Notification To Member

A. The Chief of Staff shall, upon forwarding a Report to the Medical Staff Health Advisory Committee in accordance with Article VII, Part C Section

3(A)(3)(a) above, or the Executive Committee in accordance with Article VII, Part C, Section 3 (A)(3)(b) above, send or deliver written notice to the member of the Medical Staff who is the subject of the Report (the "Reviewed Member") stating the general nature of the complaints or concerns expressed in the Report and that the matter is under review by the Medical Staff Health Advisory Committee or the Executive Committee, as applicable, for the purpose of determining whether further action is warranted.

B. If an investigation which may lead to corrective action proceeds pursuant to the Executive Committee's own determination in accordance with Article VII, Part C, Section 4 above, the Executive Committee shall send or deliver written notice to the member of the Medical Staff who is the subject of the investigation (also the "Reviewed Member") stating that the matter is under review by the Executive Committee for the purpose of determining whether corrective action is warranted.

Section 6. Automatic Recusal Of Reviewed Member

If the Reviewed Member is a member of the Medical Staff Health Advisory Committee or the Executive Committee, said Reviewed Member shall be automatically recused from any proceedings of the Executive Committee in connection with the Executive Committee's review of said Reviewed Member.

Section 7. Medical Staff Health Advisory Committee Investigation

A. If the Medical Staff Health Advisory Committee receives a Report with respect to any member of the Medical Staff, in accordance with Article VII, Part C, Section 3(A) above, or a referral from the Executive Committee in accordance with Article VII, Part C, Section 4 above, it shall conduct a confidential investigation of the matter, including interviewing the member who is the subject of the Report or referral and any other witnesses and documents it deems appropriate. Following such investigation, it shall make a determination of whether there is legitimate reason to believe that the member may be afflicted with any physical or mental illness, injury, disorder, or condition that is causing or may affect the member's ability to properly render care to patients.

B. If the Medical Staff Health Advisory Committee determines that such a legitimate reason exists, it shall:

1. Promptly advise the member in writing that it has made such a determination and that is intends to immediately refer the member to the Medical Advocacy Program of the Kansas Medical Society ("Medical Advocacy Program");

2. Promptly contact the Medical Advocacy Program and make a formal referral of the member to that program;

3. Promptly advise the Credentialing Committee that it has referred the

member to the Medical Advocacy Program; and

4. Work in active cooperation with the Medical Advocacy Program to (i) provide any information necessary, (ii) facilitate any assistance to be provided by the Medical Staff or the Hospital with respect to the Medical Advocacy Program's handling of the referral; and (iii) coordinate with the Medical Advocacy Program monitoring of the member in regard to safety patient issues during any diagnosis, treatment, or rehabilitation of the member.

C. If the Medical Staff Health Advisory Committee finds that no such legitimate reason exists, or if the member refuses to cooperate with the Committee or the Medical Advocacy Program, the Medical Staff Health Advisory Committee shall so notify the Executive Committee in writing. The Executive Committee shall then proceed in accordance with this Article VII if it deems such is warranted.

D. If the Medical Staff Health Advisory Committee deems a potential health problem to be severe enough as to cause the member to pose an imminent danger of harm to patients, other members of the Medical Staff, or members of the Hospital staff, the Medical Staff Health Advisory Committee shall recommend to the member that the he or she request a Leave of Absence pursuant to Article VII, Part F below.

E. If the member refuses to follow such a recommendation, the Medical Staff Health Advisory Committee shall notify the Chief of Staff and the CEO of the Hospital, who shall then determine whether to impose a summary suspension of the member's clinical privileges pursuant to Article VII, Part D below.

F. Notwithstanding the provisions of Article VII, Part D below, any such summary suspension shall be lifted if, prior to the Executive Committee's making a determination pursuant to Article VII, Part C, Section 8(A)(4) below, the member requests a Leave of Absence in accordance with Part F below.

G. All requests for reinstatement from a Leave of Absence taken pursuant to this section shall proceed in accordance with the Credentialing Procedures of the Medical Staff.

Section 8. Executive Committee Investigation.

A. If the Executive Committee receives a Report in accordance with Article VII, Part C, Section 3(A) above, determines, in accordance with Article VII, Part C, Section 4 above, that a matter may warrant corrective action, or receives notification from the Medical Staff Health Advisory Committee in accordance with Article VII, Part C, Section 7(C) above and determines that the matter may warrant corrective action, the Executive Committee, or a subcommittee appointed by the Executive Committee and comprised of members of the Executive Committee shall:

1. Acting on its own or through the Risk Manager of the Hospital, gather

any additional relevant information it deems necessary to thoroughly investigate the complaints or concerns expressed in the Report.

2. Interview the Reviewed Member, the person or persons who submitted the Report, if applicable, and any other person determined to have or that may have knowledge of the matters which prompted to the investigation.

3. Determine whether a physical and/or mental examination of the Reviewed Member is necessary and, upon such determination, request that the Reviewed Member submit to such an examination, at the Reviewed Member's expense, by a licensed third party physician who is approved by the Medical Advocacy Program of the Kansas Medical Society, is acceptable to both the Executive Committee and the Reviewed Member, and is not a member of the Medical Staff. The Reviewed Member shall authorize the physician performing the examination to submit a report of said physician's findings to the Executive Committee.

4. Within sixty (60) days of receiving the Report, determine, by majority vote of the Executive Committee, whether the actions, failure to take action, demeanor or conduct of the Reviewed Member constitute one or more of the grounds for corrective action, as stated in the Medical Staff Bylaws and, if so, what corrective action should be imposed. If it is the Executive Committee making such determination, the "Executive Committee," for purposes of this subsection, shall not be deemed to include any member of the Executive Committee recused in accordance with Article VII, Part C, Section 6 above.

5. Within fifteen (15) days of making a corrective action determination in relation to a Reviewed Member, prepare a written report summarizing the nature of the complaints or concerns which were investigated, its determinations (both as to the relevant facts and as to whether those facts constitute one or more grounds for corrective action), and its recommendations as to the corrective action, if any, which should be imposed upon the Reviewed Member.

6. Within fifteen (15) days of completing its report in accordance with Article VII, Part C, Section 8(A)(5) above, forward the report to the Reviewed Member and notify the Reviewed Member, in writing, in accordance with the notice requirements of Article VIII of these Bylaws. If the Executive Committee's recommendation does not involve imposing corrective action that is an "Adverse Action" pursuant to Article VIII, Part A, Section 1, the Executive Committee shall also forward its report to the Board within fifteen (15) days of completing its report.

7. If the Executive Committee recommends imposing corrective action that is an "Adverse Action" pursuant to Article VIII, Part A, Section 1, the Executive Committee shall withhold the recommendation and not forward it

to the Board until after notifying the Reviewed Member of the recommendation of the Adverse Action as set forth in Article VII, Part C, Section 8(A)(6) above and the Reviewed Member either fully exercises or waives his or her rights to a hearing and any appellate review under Article VIII.

8. When applicable, in lieu of an Executive Committee investigation as set forth in this Article VII, Part C, Section 8 above, the Executive Committee may rely upon the investigation, documentation and findings of a committee appointed by the Chief of Staff pursuant to the Medical Staff Unacceptable Conduct and Disruptive Behavior Policy.

Section 9. Board Action.

A. Subject to Article VII, Part C, Section 9(B) below, the Board shall, within forty five (45) days of receipt of the report from the Executive Committee in accordance with Article VII, Part C, Section 8(A)(6) or Section 8(A)(7) above:

1. Accept the determinations and impose the corrective action, if any, recommended by the Executive Committee;

2. Accept the determinations and impose whatever corrective action it deems appropriate, regardless of the recommendations of the Executive Committee;

3. Reject the determinations and recommendations of the Executive Committee and send the matter back to the Executive Committee with specific instructions as to further gathering of information and investigation; or

4. Reject the determinations and recommendations of the Executive Committee, substitute its own determinations, and impose or refrain from imposing any corrective action as it deems appropriate under the circumstances.

B. The Board may, at any time within the forty-five (45) day time frame for taking action pursuant to Article VII, Part C, Section 9(A) above, request further information from the Executive Committee, instruct the Executive Committee to conduct further investigation and furnish the Board information gathered from such investigation, and/or conduct its own investigation. If the Board exercises any of its rights set forth in the foregoing sentence, the Board shall make a determination under Article VII, Part C, Section 9(A) at or before its next scheduled meeting following, as applicable: (i) the receipt of such additional information; or (ii) the conclusion of its own investigation.

C. Upon reaching its determinations in accordance with Article VII, Part C, Section 9(A) above, the Board shall send written notice of its decision to the

Reviewed Member, which notice shall, in the event the decision results in the imposition of corrective action, comply with the notice requirements of Article VIII of these Bylaws.

Section 10. Risk Management Requirements

A. Kansas Risk Management Law -- Peer Review

1. The peer review and/or risk management activities shall be governed by the Hospital's internal policies and procedures and in accordance with the applicable Kansas peer review and/or risk management statutes, K.S.A. 65-4921, et seq.

2. The Executive Committee is duly constituted and charged as the committee responsible for investigating and determining applicable standards of care involving the members of the Medical Staff as required by K.S.A. § 65-4921, et seq., and more particularly K.S.A. § 65-4923. The Hospital Nursing and Allied Health Risk Management Committee is likewise duly constituted and charged as the committee responsible for investigating and determining applicable standards of care involving all non-physician employees of the Hospital Authority. All committees of the Medical Staff are charged and duly constituted to function as peer review committees, to undertake investigations, and make standards of care recommendations to the Executive Committee in compliance with Kansas law; and to evaluate and improve the quality of health care services provided in the Hospital.

3. The Executive Committee will also determine the additional factors defined in K.S.A. § 65-4915 (a) (3). The reports, statement, memoranda, proceedings, findings, and other records of the Executive Committee, and all other individuals and committees whose purposes are to assist the Executive Committee and the Hospital Authority in evaluating and improving the quality of health care services provided in the Hospital, are peer review records which are privileged and shall not be subject to discovery, subpoena, or use as evidence in any judicial or administrative proceeding, except as otherwise provided by the Executive Committee. In addition, all reports and records made by this and any other committee or individual pursuant to K.S.A. § 65-4923 or K.S.A. § 65-4924 are confidential and privileged as provided in K.S.A. § 65-4925.

4. All potentially reportable incidents committed by a Medical Staff member which may be below the applicable standard of care and have a reasonable probability of causing patient injury; or may be grounds for disciplinary action, by the appropriate state licensing agency, will be reported to the Chief of Staff or Risk Manager for investigation and evaluation. The Chief of Staff will be responsible for reporting all confirmed potentially reportable incidents to the Executive Committee of the Medical Staff. The Risk Manager is charged with making the appropriate reports to the Kansas

Board of Healing Arts and the Kansas Department of Health & Environment.

B. Safe Medical Devices

To comply with the Safe Medical Devices Act, 21 U.S.C. § 3601 (the "SMDA"), incident reports of patient equipment related events shall be made to the Chief of Staff, CEO of the Hospital, or Risk Manager. The Executive Committee is duly constituted and charged as the committee responsible to investigate potentially reportable incidents related to the SMDA. The Executive Committee shall determine whether information reasonably suggests that there is a reasonable probability that a device has caused or contributed to the death, serious illness of, or serious injury to a patient. All reports and records by the Executive Committee, any other committee of the Medical Staff, or an individual pursuant to a medical device investigation are confidential and privileged in accordance with K.S.A. § 65-4921, and K.S.A. § 65-4915. The Risk Manager is charged with making the appropriate reports to the United States Food and Drug Administration and, in the case of device-related deaths, to the manufacturer, if known.

C. National Practitioner Data Bank

Professional review actions taken by the Executive Committee that are adverse to a Medical Staff member or applicant will be reported to the National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners ("Data Bank"), as required in the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 1101, et seq. (the "HCQIA"). To be reportable, these actions must have been taken in the course of a professional review activity as defined in the HCQIA and its accompanying regulations pertaining to the Data Bank and adversely affect the clinical privileges of a physician or dentist of a period longer than thirty days. The actions must also be based on the professional competence or professional conduct of an individual practitioner which affects or could affect adversely, the health or welfare of a patient. Actions considered reportable are those that reduce, restrict, suspend, revoke, deny or fail to renew clinical privileges or membership in the Medical Staff. The voluntary surrender or restriction of clinical privileges by a member is reportable if rendered in the course of an investigation relating to possible incompetent or improper professional conduct of the member or in exchange for not conducting such an investigation. An investigation shall be deemed to be ongoing until such time as "final" action is taken, as set forth below. Final actions must be reported to the Kansas State Board of Healing Arts within fifteen days. An action is not considered "final" until approved by the Board after exhaustion of appeals, if any, as specified in these Bylaws or the Credentialing Procedures of the Medical Staff. The Risk Manager is charged with making the appropriate reports to the Kansas Board of Healing Arts.

PART D: SUMMARY SUSPENSION OR LIMITATION OF CLINICAL PRIVILEGES

Section 1. Grounds and Procedure for Summary Suspension

A. The Chief of Staff, a Clinical Service Chief, or the CEO of the Hospital or the CEO's designee shall have the authority to summarily suspend all or any portion of the clinical privileges of a Medical Staff member whenever such action must be taken immediately in the best interest of patient care or safety in the Hospital or for the continued effective operation of the Hospital. Such suspension shall be for the purpose of investigation only and shall not imply any final finding of responsibility for the situation that caused the suspension.

B. Such summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief of Staff and shall remain in effect until or unless modified by the Executive Committee or the Board.

C. Prior to the imposition of a summary suspension, the member shall be afforded an opportunity to meet with the Chief of Staff and either the Clinical Service Chief, a member of the Executive Committee, the CEO of the Hospital, or the CEO's designee, in order to explain such member's position on the matter. Details discussed during such meeting shall be documented and forwarded to the Executive Committee for consideration in the investigation described in Section 1.D below. Following such meeting, if a summary suspension is imposed, the person imposing the suspension shall provide a written notice to the suspended member stating the reason for the suspension.

D. Upon imposition of summary suspension, the person imposing the suspension shall immediately notify the Executive Committee of the suspension and the facts upon which the suspension was based. The Executive Committee, acting on its own, or through a subcommittee appointed by the Executive Committee and comprised of members of the Executive Committee, shall, within five (5) days of the imposition of a summary suspension, initiate an investigation to determine whether or not to accept, reject, or modify the summary suspension. The Executive Committee shall make such determination, based on the results of such investigation, no later than fourteen (14) days following the imposition of the summary suspension. A summary suspension shall constitute a professional review action that shall be reported to the Data Bank if in effect for longer than thirty (30) days from the day immediately following the date of such action.

E. If fourteen (14) days following the imposition of the summary suspension, the Executive Committee does not recommend immediate termination of the summary suspension, but rather recommends modification and continuance of the summary suspension, the Medical Staff member shall be entitled to Fair Hearing Rights in accordance with Article VIII. The terms of the summary suspension, as continued or modified, by the Executive Committee shall remain in effect pending a final decision thereon by the Board. If the Executive Committee recommends termination of the summary suspension, termination shall be effective immediately

upon the provision of written notice to the Medical Staff member.

Section 2. Grounds and Procedure for Voluntary Precautionary Suspension

A. As an alternative to the imposition of a summary suspension, upon a member's receipt of a notice from the Chief of Staff, a Clinical Service Chief, or the CEO of the Hospital, or the CEO's designee, that such member's actions related to the safety of patient care have been brought into question, such member may voluntarily refrain from performing the procedures in question for a period of time, not to exceed fourteen (14) days, for purposes of allowing for a proper investigation of the suspected risk.

B. A precautionary suspension shall take effect upon the member in question and the Chief of Staff, a Clinical Service Chief, or the CEO of the Hospital, or the CEO's designee, signing an agreement under which the member agrees to refrain from performing the procedures or exercising the privileges in question for a period of no more than fourteen (14) days.

C. Such precautionary suspension shall be for the purpose of investigation only and shall not imply any final finding of responsibility for the situation that caused the suspension.

D. Within the fourteen (14) day period, a precautionary suspension may lead to: a summary suspension; the initiation of formal corrective action; or termination of the suspension after a finding that the concern raised was misplaced.

Section 3. Effect of Summary and Precautionary Suspensions

Immediately upon the imposition of a summary suspension or a member's voluntary precautionary suspension, the Clinical Service Chief of the appropriate Clinical Service or, in such Clinical Service Chief's absence, the Chief of Staff shall assign responsibility for care of the suspended individual's patients still in the Hospital at the time of such suspension to another appropriate member of the Medical Staff until such time as such patients are discharged from the Hospital. If a member's summary suspension is in effect for a period greater than fourteen (14) days from the date upon which the summary suspension was initially imposed, such summary suspension shall entitle such member to a Fair Hearing pursuant to the provisions of Article VIII of these Bylaws. A member's precautionary suspension shall never constitute an "Adverse Action" pursuant to Article VIII, Part A, Section 1(G) below. It shall be the duty of the Chief of Staff and the Clinical Service Chief of the appropriate Clinical Service to cooperate with the Chief Executive Officer in enforcing all suspensions.

PART E: AUTOMATIC SUSPENSION OR LIMITATION OF CLINICAL PRIVILEGES

Section 1. Grounds for Automatic Suspension

A. The clinical privileges of a member of the Medical Staff shall automatically

be suspended for failure to complete medical records within a specified time period as defined in the Rules and Regulations of the Medical Staff. Any member failing to meet this obligation within the appropriate time period shall receive written notice at least ten (10) days prior to such member's suspension. Such member shall be eligible for reinstatement upon completion of all delinquent records.

B. Action by the applicable licensing agency of the State of Kansas revoking or suspending a member's professional license shall result in automatic suspension of the member's clinical privileges and membership in the Medical Staff as of the date of the revocation or suspension and until the matter is resolved and the license restored.

C. If a Medical Staff member's federal Drug Enforcement Administration controlled substances certificate is revoked, limited or suspended, is subject to a memorandum of understanding, is surrendered, or has expired, such Medical Staff member's privileges related to the prescription of medications covered by the certificate or license shall automatically be suspended as of the time such action becomes effective and through its term.

D. Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurance carrier, shall result in immediate and automatic suspension of a Medical Staff member's appointment and privileges until such time as a certificate of appropriate insurance coverage is furnished.

E. Involuntary termination, exclusion or other prohibition from participation in the Medicare or Medicaid or any state or federal health care program such that a Medical Staff member's name appears on the General Service Administration's List of Parties Excluded from Federal health care programs (the "Excluded Parties List"), shall result in automatic relinquishment of all clinical privileges until such time as the exclusion or prohibition is lifted and the Medical Staff member's name no longer appears on the Excluded Parties List.

F. If a Medical Staff member pleads guilty to or is found guilty of a felony or misdemeanor related to controlled substances, illegal drugs, Medicare, Medicaid or insurance fraud or abuse the Medical Staff member's appointment and privileges shall be immediately and automatically suspended. The Credentialing Committee shall investigate such matters and make a recommendation to the Executive Committee.

G. Failure by a Medical Staff member to successfully complete the FPPE or OPPE process as set forth in the FPPE Policy and OPPE Policy, respectively, or the failure by a Medical Staff member to comply with any corrective action plan that results from the OPPE process, shall result in the automatic relinquishment of all such privileges that are subject to the FPPE or OPPE process, until such time as the member successfully completes the FPPE or OPPE process, or the member's privileges are reinstated following a Fair Hearing in accordance with Article VIII.

Section 2. Procedure for Automatic Suspension

Upon the occurrence of any of the grounds for automatic suspension of a Medical Staff member's clinical privileges, the Chief of Staff shall immediately and automatically revoke the member's clinical privileges. If a member of the Medical Staff fails to eliminate the deficiency giving rise to the grounds for an automatic suspension (or to provide documentation of reasonable satisfaction of such to the Chief of Staff), within sixty (60) days of receipt of the notice of suspension, the imposed action shall be deemed permanent and the Medical Staff member must seek appointment in accordance with Article VI. If a Medical Staff member submits documentation to the reasonable satisfaction of the Chief of Staff of the elimination of the deficiencies, the suspension imposed upon such Medical Staff member shall be revoked and the Medical Staff member reinstated, effective upon the date of such determination by the Chief of Staff.

PART F: LEAVE OF ABSENCE

Section 1. Grounds

A leave of absence may be granted to any member by the Board in accordance with the Credentialing Procedures of the Medical Staff. All Active members who, for any reason, will not exercise their clinical privileges for a period of more than six (6) months must request a leave of absence in accordance with the Credentialing Procedures of the Medical Staff.

Section 2. Period

Any such leave of absence shall be granted for a specified period not to exceed one year except for military service. During the period of time of the leave, the member's clinical privileges, prerogatives and responsibilities shall be suspended.

Section 3. Effect on Membership

A Member's leave of absence shall not suspend or defer his or her current appointment to the Medical Staff, and shall not relieve a Member of his or her obligation to reapply for appointment pursuant to the Credentialing Procedures of the Medical Staff.

Section 4. Reinstatement

Members wishing to be reinstated following a leave of absence granted in accordance with Article VII, Part F, Section 1 above must apply for reinstatement in accordance with the Credentialing Procedures of the Medical Staff.

PART G: VOLUNTARY RESIGNATION

Resignations from the Medical Staff and/or relinquishment of clinical privileges shall be submitted in writing to the relevant Clinical Service Chief for transmittal to the Executive Committee and will be effective on the date stated in the writing with no formal action required. The Chief of Staff will acknowledge receipt of the resignation, in writing, and the member will be

promptly notified of any medical records containing documentation deficiencies.

When a member's resignation is accepted or clinical privileges are relinquished during the course of an investigation related to potential corrective action in accordance with Article VII, Part C related to issues of clinical competency or professional conduct, a report will be submitted to the National Practitioner Data Bank, as required by law.

ARTICLE VIII: FAIR HEARING

PART A: FAIR HEARING ENTITLEMENT

Section 1. All members of the Medical Staff and applicants for membership in the Medical Staff, except Allied Health Professionals, and persons who have applied for clinical privileges as Allied Health Professionals, shall be entitled to a hearing ("Fair Hearing") in the manner described in, and subject to the conditions of, this Article VIII ("Fair Hearing Rights"), if the Executive Committee or the Board (either are sometimes referred to as the "Acting Body") recommends or undertakes an Adverse Action, as defined below, against them. All such members or applicants entitled to exercise Fair Hearing Rights and against whom an Adverse Action is taken shall hereinafter be referred to as "Affected Persons". For purposes of this Article VIII, the term "Adverse Action" shall mean:

A. Denial of an Affected Person's application for initial appointment to the Medical Staff or limitation of the Affected Person's clinical privileges as requested in said application;

B. Denial of an Affected Person's application for reappointment to the Medical Staff or limitation of the Affected Person's clinical privileges as requested in said application;

C. Denial of an Affected Person's application for modification of clinical privileges or limitation of the Affected Person's clinical privileges as requested in said application;

D. Revocation of an Affected Person's membership in the Medical Staff or any prerogative of said Affected Person's membership in the Medical Staff;

E. Revocation of any portion of a Affected Person's clinical privileges;

F. Suspension of an Affected Person's membership in the Medical Staff, or any prerogative of said Affected Person's membership in the Medical Staff, if said suspension or limitation lasts or is scheduled to last for a period of greater than thirty (30) days; or

G. Suspension or limitation of any portion of an Affected Person's existing clinical privileges, if said suspension or limitation lasts or is scheduled to last for a

period of greater than thirty (30) days.

H. Summary suspension of Affected Person's membership on the Medical Staff if the summary suspension lasts for longer than fourteen (14) days.

Section 2. Notwithstanding the language of Article VIII, Part A, Section 1 above, the following actions shall not entitle a member of the Medical Staff or applicant for membership in the Medical Staff to exercise Fair Hearing Rights:

A. Suspension of a member's admitting prerogatives due to the member's failure to complete medical records in a timely fashion if said suspension is limited only to the time period during which the records upon which the suspension is based remain incomplete;

B. Denial of a member's request to change categories of medical staff membership;

C. Denial of a request that an applicant be granted temporary clinical privileges, denial of an applicant's request to be appointed as a Limited Privilege Practitioner, denial of an applicant's request to be granted disaster clinical privileges, or the limitation, suspension or revocation of an applicant's temporary clinical privileges, an applicant's disaster clinical privileges or a person's status as a Limited Privilege Practitioner; or

D. Issuance of a letter of reprimand, letter of admonition or any other action which does not adversely affect the clinical privileges of the member.

Section 3. Single Hearing.

An Affected Person shall be entitled to only one Fair Hearing with respect to any and all Adverse Action(s) resulting from or arising out of the same occurrence or related occurrences, or common set of circumstances or operative facts. Notwithstanding the foregoing, the Board may consolidate more than one Fair Hearing in relation to an Affected Person, if more than one Fair Hearing is required by these Bylaws, and circumstances warrant the consolidation of multiple Fair Hearings. If the Affected Person has either requested, had, or forfeited a Fair Hearing or waived said Affected Person's Fair Hearing Rights following an Adverse Action or related series of Adverse Actions taken by the Executive Committee, said Affected Person shall not for any reason become entitled to another Fair Hearing with respect to any Adverse Action or related series of Adverse Actions or any modification thereof.

PART B: INITIATION OF HEARING

Section 1. Notice of Hearing Rights

If the Acting Body recommends or undertakes an Adverse Action against an Affected Person, the notice to the Affected Person accompanying such action as required by the

Medical Staff Bylaws and/or these Procedures, shall be personally delivered or sent certified mail, return receipt requested. Said notice shall state the action taken, the reason(s) for the action, and the requirements for requesting a Fair Hearing as expressed in Article VIII, Part B, Section 2 below. Said notice shall also include a copy of these Bylaws.

Section 2. Exercise of Hearing Rights

Within thirty (30) days of the Affected Person's receipt of a written notice in accordance with Article VIII, Part B, Section 1 above, the Affected Person shall, if he or she desires a Fair Hearing in accordance with this Article VIII, deliver a written request for a Fair Hearing to the Chief of Staff (if the action was taken by the Executive Committee and the Chief of Staff is not the Affected Person), the Vice Chief of Staff (if the action was taken by the Executive Committee and the Chief of Staff is the Affected Person), or the Chair of the Board (if the action was taken by the Board) (the Chief of Staff, Vice Chief of Staff, and Chair of the Board are, in this capacity, referred to herein as the "Appropriate Officer"). The Affected Person's failure to request a Fair Hearing in accordance with the requirements of this Article VIII, Part B, Section 2 shall result in a waiver of the Affected Person's rights to a hearing and any appellate review under this Article VIII.

Section 3. Consent Agreement

At any time following the Affected Person's receipt of a notice of an Adverse Action, the Affected Person may elect to enter into a consent agreement upon terms and conditions acceptable to the Executive Committee and the Board. Such consent agreement may provide for the waiver or termination of the Fair Hearing or corrective action and procedural rights, and shall specify the rights and obligations of the Affected Person under the consent agreement and upon any termination thereof.

PART C: HEARING REQUIREMENTS

Section 1. Notice of Time and Place of Hearing

Within ten (10) days after receipt of a request which complies with the requirements of Article VIII, Part B, Section 2 above, the Appropriate Officer shall commence scheduling and arranging for a Fair Hearing in accordance with this Article VIII. At least thirty (30) days prior to the hearing, the Appropriate Officer shall send notice to the Affected Person of the time, place, and date of hearing. The notice of the hearing provided to the Affected Person shall include a list of witnesses expected to testify and documents expected to be used at the hearing in support of the Adverse Action. Within ten (10) days of receiving such notice, the Affected Person shall provide a list, in writing, of witnesses expected to testify on the Affected Person's behalf at the Fair Hearing and documents expected to be used by or on behalf of the Affected Person at the Fair Hearing.

Section 2. Hearing Body

The hearing may be conducted before either a Hearing Officer or a Hearing Committee as determined by the Appropriate Officer in his or her sole and absolute discretion.

A. Appointment of Hearing Officer and Presiding Officer

1. If the Appropriate Officer decides to appoint a Hearing Officer to conduct the hearing, the Appropriate Officer may select a physician, dentist, attorney, or other individual qualified to serve as the Hearing Officer. The Hearing Officer is not required to be a member of the Medical Staff. The Hearing Officer shall not be in direct economic competition with the Affected Person or otherwise have a conflict of interest with the Affected Person.

2. The Appropriate Officer may designate an individual qualified to conduct hearings as the presiding officer ("Presiding Officer") for any matter to be heard by the Hearing Officer. The Presiding Officer shall not deliberate or vote on matters to be decided by the Hearing Officer and shall not be in direct economic competition with the Affected Person or otherwise have a conflict of interest with the Affected Person. If appointed, the Presiding Officer shall preside over the hearing as described in Article VIII, Part D, Section 2 below.

B. Appointment of Hearing Committee

1. If the Appropriate Officer decides to appoint a Hearing Committee before which to conduct the hearing, said Hearing Committee shall consist of at least three (3) individuals, one of whom shall be designated as the chair by the Appropriate Officer. All persons appointed to the Hearing Committee shall be members of the Medical Staff unless, because of the requirements of Article VIII, Part C, Section 2(B)(2) below, a sufficient number of qualified members cannot be appointed, in which case the Appropriate Officer may appoint other licensed physicians to the Hearing Committee.

2. A member of the Medical Staff or other licensed physician shall not be disqualified from serving on a Hearing Committee merely because he or she participated in initiating or investigating the underlying matter at issue or because he or she has heard of the matter. However, no member of the Hearing Committee may be in direct economic competition with the Affected Person.

3. The Appropriate Officer may designate an individual qualified to conduct hearings as the Presiding Officer for any matter to be heard by the Hearing Committee. The Presiding Officer need not be a member of the Hearing Committee, and shall not deliberate or vote on matters to be decided

by the Hearing Committee.

Section 3. Pre-Hearing Conference

Prior to the hearing, the chair of the Hearing Committee or the Hearing Officer may conduct a pre-hearing conference. At such conference the Affected Person, his or her counsel or representative, if any, and a representative of the Acting Body shall attend to discuss stipulations of fact, amendment to the grounds for action or the issues at dispute, and changes in the witness lists. Additionally, those in attendance may discuss the procedure for the conduct of the hearing and/or the possibility of resolution by consent. The Hearing Committee or the Hearing Officer may require the Affected Person and the Acting Body to submit an outline setting forth, so far as the parties reasonably know:

A. The issues to be raised at the hearing;

B. Witnesses to call at the hearing and the subject matter upon which such witnesses will testify;

C. A description of written or documentary evidence the parties intend to introduce as evidence at the hearing; and

D. A short summary of matters the parties will demonstrate at the hearing.

PART D: HEARING PROCEDURE.

Section 1. Forfeiture of Hearing

An Affected Person who requests a hearing pursuant to this Article VIII but fails to appear at the hearing without good cause, as determined by the Hearing Committee or Hearing Officer, shall forfeit his or her rights to such hearing.

Section 2. Presiding Officer

The Hearing Officer or Presiding Officer, or the chair of the Hearing Committee in the absence of a Presiding Officer, shall preside over the hearing. He or she shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence in an orderly fashion. He or she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

Section 3. Representation

The Affected Person who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the Medical Staff in good standing, or by an attorney. The Acting Body may appoint a member of the Medical Staff or an attorney to represent it at the hearing, to present factual and other relevant evidence in support of the Adverse Action, and to examine witnesses.

Section 4. Rights of Parties

A. During the hearing, each of the parties shall have the right to:

1. Call, examine and cross-examine witnesses;

2. Introduce any relevant evidence, including documents and other exhibits;

3. Question any witnesses on any matter relevant to the issues;

4. Impeach any witness;

5. Rebut any evidence;

6. Make a record of the hearing by use of a court reporter or an electronic recording unit at the party's expense; and

7. Submit a written summary after the close of the hearing.

B. The Affected Person may choose the point during the hearing at which he or she will give testimony and shall be permitted to give his or her direct testimony prior to submitting to cross-examination. However, the Affected Person may not refuse to testify and may be called and cross-examined if he or she otherwise refrains from testifying prior to the conclusion of the presentation of all other oral and written evidence to be presented at the hearing.

Section 5. Procedure and Evidence

Prior to a hearing, the Affected Person may obtain redacted copies, at his or her own expense, of relevant documentary information, including patient charts, relevant portions of committee minutes pertaining to the Adverse Action and other similar documents supporting or related to the Adverse Action; provided however, that the Affected Person shall not have access to confidential Hospital or Medical Staff records not relevant to the subject matter of the hearing. As a condition precedent to disclosure of such redacted copies, the Affected Person, and the Affected Person's representative, if any, shall agree in writing to protect the confidentiality of records so disclosed, and to refrain from further disclosure of such records except as necessary to participate in the hearing. If the Affected Person, and the Affected Person's representative, if any, does not agree in writing to protect the confidentiality of such records, then the Affected Person may not access such documentary information.

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. However, the Affected Person shall not be permitted to introduce any evidence, or have access to any peer review documents, medical records, minutes or other documents related to any other Medical Staff

member or Hospital employee, or any action taken or not taken with regard to any other Medical Staff member or Hospital employee.

Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issues of law or fact, and such memoranda shall become a part of the hearing record. The Hearing Officer or Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

Section 6. Written Summaries

Any party to the hearing who wishes to submit a written summary discussing the evidence presented at the hearing and arguing the merits of the case must do so within five (5) days after the close of the hearing, although the Hearing Officer or chair of the Hearing Committee, in his or her discretion, may grant an extension of time upon a showing of good cause. Such written summaries shall refer to and rely upon only the testimony and other evidence admitted into evidence by the person who presided over the hearing. Any written summary containing references to evidence, witnesses or matters excluded or not offered as evidence by either party shall be refused. All written summaries shall be delivered to the Hearing Officer or chair of the Hearing Committee, with copies contemporaneously delivered to the opposing party. Neither oral nor written rebuttals to matters contained in any written summary shall be permitted.

Section 7. Information Pertinent To Hearing

In reaching a decision, the Hearing Committee or Hearing Officer shall be entitled to consider all information relevant to the Adverse Action.

Section 8. Burden of Proof

The Acting Body shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the Affected Person who requested the hearing to present evidence. After all the evidence has been presented by both sides, the Hearing Committee or Hearing Officer shall recommend in favor of the body whose action prompted the hearing unless it finds that the Affected Person who requested the hearing has proved, by clear and convincing evidence, that the recommendation or action that prompted the hearing was arbitrary, unreasonable, capricious, or not supported by any rational basis.

Section 9. Record of Hearing

A record of the hearing shall be kept with sufficient accuracy such that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Hearing Committee or Hearing Officer may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. An Affected Person electing a method not selected by the Hearing Committee or Hearing

Officer shall bear the cost of such. Otherwise, the cost of such recording shall be borne by the Hospital.

Section 10. Postponement

Requests for postponement of a hearing may be granted by the chairman of the Hearing Committee or the Hearing Officer upon a showing of a good cause.

Section 11. Recesses and Adjournment

The Hearing Committee or Hearing Officer may recess the hearing and reconvene it without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

PART E: REPORT AND FURTHER ACTION.

Section 1. Hearing Officer/Hearing Committee Determinations.

Within twenty (20) days after the deadline for submitting written summaries pursuant to Article VIII, Part D, Section 6 above, as such deadline may be extended in accordance with said subsection, the Hearing Officer or Hearing Committee (by majority vote) shall make its findings and recommendations regarding the Adverse Action and shall prepare a written report of such and forward such written report, together with the hearing record and all other documentation considered by it, to the Acting Body. The report shall include a statement of the basis for the Hearing Officer's or Hearing Committee's recommendations. A copy of the report shall be provided contemporaneously to the Affected Person.

Section 2. Action on Report.

Within twenty (20) days after receipt of the report, the Acting Body shall reconsider the adverse action in light of the Hearing Officer's or Hearing Committee's report and affirm, modify or reverse the Adverse Action. The decision shall be in writing and shall include a statement as to its basis.

Section 3. Effect of Result.

A. If the Executive Committee is the Acting Body, it shall forward its written recommendations, as they may have been reaffirmed or modified upon reconsideration, to the Board and the Affected Person along with a copy of the Hearing Officer's or Hearing Committee's report within fifteen (15) days of the meeting at which said recommendations were reaffirmed or modified. The Board shall, within thirty (30) days of its receipt of said recommendations, either accept, reject or modify the recommendations in any manner permitted in these Bylaws refer the matter back to the Executive Committee for further consideration, stating the purpose for such referral and the time within which further action is to be taken by the Executive Committee. The Board shall send written notice of its

decision to the Affected Person within fifteen (15) days of the meeting in which said decision was made.

B. If the Board is the Acting Body, it shall forward its written decision, as it may have been reaffirmed or modified upon reconsideration, to the Executive Committee and the Affected Person along with a copy of the Hearing Officer's or Hearing Committee's report.

PART F: APPELLATE REVIEW BY THE BOARD

Section 1. Appellate Review Timeline.

Within ten (10) calendar days after receipt of a notice of an adverse decision by the Board following a hearing, as provided above, an Affected Person may, by written notice to the CEO of the Hospital ("CEO"), request an appellate review of the adverse decision by a committee of Board members ("Appellate Review Request"). If the Affected Person wishes an attorney to represent him or her at any such appellate review appearance, the Appellate Review Request shall so state. The CEO will provide a copy of the Appellate Review Request to the Chair of the Board.

Section 2. Waiver of Appeal.

If the Appellate Review Request is not received by the CEO within the ten (10) calendar days described in Section 1, the Affected Person shall be deemed to have waived any and all rights to appeal and to have accepted the adverse decision, and the adverse decision shall become effective immediately and become final and non-appealable.

Section 3. Time and Place for Appellate Review.

In the event the Appellate Review Request is received by the CEO within the ten (10) day period in Section 1 above, then within thirty (30) calendar days after receipt by the CEO of the Appellate Review Request, the Chair of the Board will schedule a date, time and place for such review and will, through the CEO by written notice sent by certified mail, notify the Affected Person of the same. The date of the appellate review shall not be less than fourteen (14) calendar days from the date of receipt by the CEO of the Appellate Review Request, and not more than forty five (45) calendar days from the date of receipt by the CEO.

Section 4. Appellate Review Body.

The Chair of the Board will appoint an appellate review body composed of three (3) or more members of the Board ("Appellate Review Body"). One (1) of its members will be designated by the Chair of the Board as chair of the Appellate Review Body.

Section 5. Board Appellate Review Procedure.

A. The Appellate Review Body will review the record of the hearing before the Hearing Committee or Hearing Officer, the Hearing Committee or Hearing Officer's report, and all subsequent results and actions thereof (collectively, the "Hearing Record"). The Appellate Review Body may also consider any written statements submitted pursuant to Subsection B. of this Section 5 and such other oral information as may be presented during the hearing consistent with Section 6.

B. The Affected Person shall submit a written statement of the Affected Person's position to the Appellate Review Body at least ten (10) calendar days prior to the date scheduled for the appellate review. The Affected Person's statement should describe the reasons he or she believes the adverse decision of the Acting Body should be modified or reversed, consistent with the Scope of Review as defined in Section 8. The Chair of the Appellate Review Body may provide a copy of the Affected Person's statement to the Acting Body. The Acting Body may submit a written statement any time prior to the date of the appellate review as to why its adverse decision should be upheld. The failure of the Acting Body to submit such a written response will not, in and of itself, constitute a basis for the Appellate Review Body to recommend modifying or reversing the decision of the Acting Body (pursuant to Section 8), nor as a basis for the Board to decide to modify or reverse the decision of the Acting Body (pursuant to Section 9).

Section 6. Conduct of the Appellate Review.

A. The chair of the Appellate Review Body will preside over the appellate review, including determining the order of procedure, making all required rulings, and maintaining decorum during all proceedings.

B. The Appellate Review Body will allow the Affected Person and the Acting Body ("Party" or "Parties") or their representatives (including attorneys) to appear and make oral statements. The oral statement of each Party, its representatives and attorneys will not, in the aggregate, exceed 30 minutes. Parties or their representatives and attorneys appearing before the Appellate Review Body must answer questions posed to them by the Appellate Review Body. The failure of the Acting Body to appear and make an oral statement will not, in and of itself, constitute a basis for the Appellate Review Body to recommend modifying or reversing the decision of the Acting Body (pursuant to Section 8), nor as a basis for the Board to decide to modify or reverse the decision of the Acting Body (pursuant to Section 9).

C. Neither the written statements described in Section 5.B., nor the oral statements described in Section 6.B., can include evidence or information not otherwise in the Hearing Record. The appellate review is limited to the Hearing Record and the Appellate Review Body cannot consider evidence not part of the Hearing Record.

Section 7. Recess of Appellate Review Proceedings.

The Appellate Review Body may recess the appellate review proceedings and reconvene the same without additional notice for the convenience of the Appellate Review Body or the Parties or consultation required for resolution of the matter. Upon the conclusion of oral statements the appellate review shall be closed to further participation or written or oral comments of the Parties. The Appellate Review Body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Parties. Upon the conclusion of such deliberations, the appellate review shall be declared finally adjourned. The Appellate Review Body shall endeavor to render its written recommendation to the Board within ten (10) calendar days following the conclusion of deliberations, unless the matter is referred back to the Hearing Committee or Hearing Officer as described in Section 8, in which case the timeline in Section 8 will apply.

Section 8. Scope of Review and Recommendation to the Board.

The Appellate Review Body may recommend that the Board affirm, modify or reverse the adverse decision, or, in its discretion, may refer the matter back to the Hearing Committee or Hearing Officer for further review and recommendation. In such event, the Hearing Officer or Hearing Committee must conclude their further review and send their conclusions to the Appellate Review Body within ten (10) calendar days and in accordance with the Appellate Review Body's instructions. Within ten (10) calendar days after receipt of the Hearing Committee's or Hearing Officer's response, the Appellate Review Body shall make its written recommendation to the Board. Notwithstanding anything herein to the contrary, the Appellate Review Body can only recommend modifying or reversing the adverse decision if the Appellate Review Body concludes that the Affected Person who has requested the appellate review has proved, by clear and convincing evidence, that the adverse decision was arbitrary, unreasonable, capricious, or not supported by any rational basis ("Scope of Review").

Section 9. Decision by the Board.

Within sixty (60) calendar days after receipt of the Appellate Review Body's written recommendation, the Board shall make its final decision in the matter. During this period, the Board may consult legal counsel, members of the Executive Committee, the Chief of Staff, members of the Hearing Committee, the Hearing Officer, witnesses, or others the Board deems appropriate. Notwithstanding anything herein to the contrary, the Board can only modify or reverse the adverse decision if the Board concludes that the Affected Person who has requested the appellate review has proved, by clear and convincing evidence, that the adverse decision was arbitrary, unreasonable, capricious, or not supported by any rational basis. When the Board has made its final decision in the matter, it shall send written notice of its decision to the CEO of the Hospital, who shall deliver copies of the decision to the Chief of Staff, the Executive Committee, and the Affected Person. Upon such delivery by the CEO to the

Affected Person, the Board's decision shall be immediately effective and final, and the matter shall not be subject to any further referral or review.

Section 10. Review Limited to One Hearing and One Appellate Review.

Notwithstanding any other provision of these Bylaws, no Affected Person shall be entitled as a right to more than one (1) hearing and one (1) appellate review on any matter which shall have been the subject of an Adverse Action by the Executive Committee, the Board or both.

ARTICLE IX: RELEASE AND IMMUNITY FROM LIABILITY

PART A: Any member or representative of the Medical Staff, Board, Hospital, Hospital Authority, and any department or committee thereof (the "Immunized Parties"), shall be exempt, and shall have absolute immunity, from liability to a person applying for initial appointment to the Medical Staff, or to any member of the Medical Staff, for damages or other relief for any action taken or statements or recommendations made within the scope of said person's duties hereunder as a representative of the Immunized Parties, or any department or committee thereof, or as a member, agent, employee, advisor, counselor, consultant, or attorney providing services to or through the Immunized Parties, their departments, clinical services or committees in conjunction with all actions hereunder, including, but not limited to, the evaluation of an applicant for initial appointment to the Medical Staff, the ongoing evaluation of a member of the Medical Staff, or any corrective action procedures.

PART B: Each representative of the Immunized Parties, and all third parties, shall be exempt from liability to an applicant for initial appointment to the Medical Staff, or to a member of the Medical Staff, for damages or other relief by reason of providing information to a representative of the Immunized Parties concerning such applicant or member.

PART C: The immunity provided by this Article IX shall apply to all acts, communications, reports, recommendations, or disclosures permitted or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to: (i) applications for initial appointment to the Medical Staff, reappointment to the Medical Staff, or modifications in clinical privileges; (ii) corrective action; (iii) hearings and appellate reviews, including Fair Hearings; (iv) peer review, quality improvement, and utilization review activities; and (v) other departmental, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

ARTICLE X: RELATIONSHIP OF THE HOUSE STAFF TO THE MEDICAL STAFF

PART A: The House Staff of the Hospital consists of physicians or dentists who are in specialty, subspecialty or fellowship training in a Clinical Service. Such trainees must be appropriately licensed in the State of Kansas. The appropriate size of the House Staff in a given Clinical Service shall be determined by the Dean in consultation with the Clinical Service Chief of the particular Clinical Service and the CEO of the Hospital. Position descriptions for each

postgraduate year in each specialty, subspecialty or fellowship training program shall be developed by the Clinical Service sponsoring the program and filed in the office of the Chief of Staff.

PART B: Any medical activities or professional services performed by a member of the House Staff shall be supervised by a member of the medical staff who has appropriate privileges. All medical activities and services performed by a member of the House Staff will be appropriate to the trainee's level of seniority in the particular program as outlined in the applicable position description.

PART C: The relationship of the House Staff to the Medical Staff shall be overseen jointly by the Executive Committee and the University of Kansas Medical Center's Graduate Medical Education Committee. The Executive Committee shall regularly receive reports from the University of Kansas School of Medicine's Office of Graduate Medical Education and shall interact directly with the Office of Graduate Medical Education in connection with its oversight responsibilities. The Hospital, each Clinical Service, and the Medical Staff shall cooperate in the supervision and evaluation of the performance of the House Staff.

PART D: The rights and responsibilities of the House Staff are defined in the University of Kansas's "Policies and Procedures Governing Graduate Medical Education." Any administrative actions relating to a member of the House Staff must be conducted in accordance with the "Policies and Procedures Governing Graduate Medical Education." Members of the House Staff are not entitled to any of the rights, responsibilities or privileges granted to members of the Medical Staff.

ARTICLE XI: OTHER RULES, REGULATIONS, POLICIES AND PROCEDURES OF THE MEDICAL STAFF

PART A: ADOPTION OF RULES AND REGULATIONS, POLICIES AND PROCEDURES OF THE MEDICAL STAFF

The Executive Committee shall adopt Rules and Regulations, Credentialing Procedures, Committee Procedures, and any other policies and procedures which may be necessary, to implement more specifically the general principles of conduct found in these Bylaws. The Rules and Regulations, Credentialing Procedures, Committee Procedures, and any other policies and procedures adopted by the Executive Committee, shall set forth standards of practice that are to be required of each physician and dentist in the Hospital and shall act as an aid to evaluating performance and compliance with such standards. They shall have the same force and effect as the Bylaws.

PART B: AMENDMENT TO RULES AND REGULATIONS, CREDENTIALING PROCEDURES, AND COMMITTEE PROCEDURES

Section 1. Process and Notice and Comment Period for Executive Committee Amendment to the Rules.

The Rules and Regulations, Credentialing Procedures, and Committee Procedures (collectively, the "Rules") adopted by the Executive Committee, may be amended by the Executive Committee. Prior to amending the Rules, the Executive Committee must first communicate the proposed amendment to the Medical Staff for review and comment. This review and comment opportunity shall be accomplished by circulating the proposed amendment to all medical staff members at least thirty (30) days prior to the scheduled Executive Committee meeting, together with instructions on how interested members may communicate their comments to the Executive Committee. A comment period of at least fifteen (15) days shall be afforded, and all comments shall be summarized and provided to the Executive Committee prior to the Executive Committee's action on the proposed changes or additions.

Section 2. Process for Medical Staff Amendment to the Rules.

As an alternative to the Executive Committee proposing an amendment to the Rules, the members of the Active staff may propose an amendment to the Rules by a petition signed by at least forty percent (40%) of the members of the Active staff. Such petition shall first be submitted to the Executive Committee for its consideration and approval. The Executive Committee shall act on such petition at its next scheduled meeting.

Section 3. Executive Committee Approval of Amendments Proposed By Medical Staff.

The Executive Committee's approval is required on all amendments to the Rules, unless the petition described in Section 2 above was generated by at least two-thirds (2/3) of the members of the Active staff, in which case, if the Executive Committee does not approve the proposed amendment, the Executive Committee shall give the medical staff notice within ten (10) days of its decision, and the Active staff members may choose to present the proposed amendment to the Rules directly to the Board for approval. If the proposed amendment was not generated by a petition of at least two-thirds (2/3) of the members of the Active staff and the Executive Committee fails to approve the proposed amendment, the proposed amendment shall be submitted to the Active members of the medical staff for a formal vote, and if approved by two-thirds (2/3) of the members of the Active staff, shall be forwarded to the Board for approval and implementation.

Section 4. Board Approval of Amendments to the Rules.

Following approval by the Executive Committee, the presentation of an amendment to the Rules by petition of at least two-thirds (2/3) of the Active members of the medical staff, or the approval of an amendment to the Rules proposed through a petition as described in Section 3, the proposed amendments shall be forwarded to the Board for approval. The amendment to the Rules shall become effective immediately following approval by the Board, unless otherwise indicated, or automatically within sixty (60) days if no action is taken by the Board.

Section 5. Urgent Amendment to the Rules.

In cases of a documented need for an urgent amendment to the Rules in order to comply with a law or regulation, the Executive Committee may provisionally adopt such an amendment and forward it to the Board for approval and immediate implementation without prior notification of the medical staff. The medical staff will then be immediately notified by the Executive Committee of the provisionally adopted and approved Rule. The Medical staff shall then have the opportunity for retrospective review of and comment on the provisional amendment. The Medical Staff may, by a petition signed by at least two-thirds (2/3) of the Active staff members require that the Rule be reconsidered; provided, however, the approved Rule shall remain effective until such time as a superseding Rule meeting the requirements of the law or regulation has been approved.

PART C: AMENDMENT TO OTHER MEDICAL STAFF POLICIES

Section 1. Amendment of the Policies by the Executive Committee.

The Executive Committee may adopt or amend any other policies or procedures of the Medical Staff as it sees fit (collectively, "Policies").

Section 2. Process for Medical Staff Amendment to the Policies.

As an alternative to the Executive Committee amending the Policies through its delegated authority, the members of the Active staff may propose an amendment to the Policies by a petition signed by at least forty percent (40%) of the members of the Active Staff submitted to the Executive Committee for its consideration and approval.

Section 3. Executive Committee Approval of Amendments Proposed By Medical Staff.

The Executive Committee's approval is required on all amendments to the Policies, unless the petition described in Section 2 above was generated by at least two-thirds (2/3) of the members of the Active staff; in which case, if the Executive Committee does not approve the amendment, the Executive Committee shall give the medical staff notice within ten (10) days of its decision, and the Active staff members may choose to present the proposed amendments to the Policies directly to the Board for approval. If the proposed amendment was not generated by petition of at least two-thirds (2/3) of the members of the Active staff and the Executive Committee fails to approve the proposed amendment, the proposed amendment shall be submitted to the Active members of the medical staff for a formal vote, and if approved by two-thirds (2/3) of the members of the Active staff, shall be forwarded to the Board for approval and implementation.

Section 4. Board Approval of Amendments of the Policies.

Following approval by the Executive Committee, the presentation of an amendment to the Policies by petition of at least two-thirds (2/3) of the Active members of the medical staff, or the approval of an amendment to the Policies proposed through a petition as described in Section 3, the proposed amendments shall be forwarded to the Board for approval. The amendment to the Policies shall become effective immediately following

approval by the Board, unless otherwise indicated, or automatically within sixty (60) days if no action is taken by the Board.

Section 5. Medical Staff Notification of Amendments of the Policies.

The medical staff shall be notified immediately of all Policies approved by the Executive Committee and the Board.

ARTICLE XII: REVIEW AND AMENDMENT

PART A: REVIEW

These Bylaws shall be reviewed by the Executive Committee as often as necessary but at least annually.

PART B: AMENDMENT

These Bylaws may be amended as follows:

Section 1. Amendments may be proposed by the Board, the Executive Committee, or by no fewer than ten percent (10%) of the Active staff and shall be submitted in writing or electronically to the Chief of Staff no fewer than ten (10) days prior to any Annual Meeting or a Special Meeting called for the purpose of amending these Bylaws.

Section 2. The Chief of Staff shall place any proposed amendment submitted in accordance with Article XII, Part B, Section 1 above on the agenda for the Annual Meeting or Special Meeting at which the proposed amendment will be discussed and shall permit discussion on said proposed amendment at such Annual Meeting or Special Meeting.

Section 3. Within five (5) business days after the Annual Meeting or Special Meeting at which any amendment is proposed in accordance with Article XII, Part B, Section 2 above, the Nominations and Elections Committee shall prepare and deliver to each Member of the Active staff a written or electronic ballot clearly stating the language of the proposed amendment, the date by which the ballot must be returned, and the physical or e-mail address to which the ballot must be returned.

Section 4. Within fifteen (15) business days after the Annual Meeting or Special Meeting at which any amendment is proposed in accordance with Article XII, Part B, Section 2 above, members of the Active staff shall return their marked ballots to the Nominations and Elections Committee at the address indicated on the ballot.

Section 5. Within thirty (30) business days after the Annual Meeting or Special Meeting at which any amendment is proposed in accordance with Article XII, Part B, Section 2 above, the Nominations and Elections Committee shall tally and announce the results of the balloting. Any proposed amendment must receive the affirmative vote of at least two-thirds of the members of the Active staff who returned their ballots on a timely basis and must be

submitted to and receive the approval of the Board prior to becoming effective.

Section 6. Notwithstanding Article XII, Part B, Sections 1 through 5 above, the Executive Committee shall have the power to adopt such amendments to these Bylaws necessary for reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other grammar or expression or inaccurate cross references. Any such amendment or revision will be effective upon Executive Committee approval and adoption by the Board.

Approved:

Louis H. Wetzel, M.D., Chief of Staff
University of Kansas Hospital Medical Staff

Date: November 29, 2013

Bob Page, President and CEO
University of Kansas Hospital Authority

Date: December 10, 2013

EXHIBIT F

Cohen, Melissa <melissa.cohen@ppfa.org>

FW: **Hospital Bylaws**

1 message

McQuade, Laura [redacted]> Tue, Jan 24, 2017 at 6:53 PM
To: "Cohen, Melissa" <Melissa.Cohen@ppfa.org>

President & CEO

Planned Parenthood Great Plains (PPGP)

Planned Parenthood Great Plains Votes (PPGPV)

[redacted]

www.PPGreatPlains.org | www.PPGPVotes.org

From: [redacted]@carondelet.com]
Sent: Tuesday, October 11, 2016 6:02 PM
To: McQuade, Laura [redacted]>
Subject: Re: Hospital Bylaws

Sorry. You are correct.

[redacted]

Sent from IPhone 7+

On Tue, Oct 11, 2016 at 5:40 PM -0500, "McQuade, Laura" <[redacted]> wrote:

Thank you for responding, [redacted]. Just to clarify, unfortunately, I am assuming that the first sentence of your email should read that you will not be able to send the bylaws. Is that right?

Laura McQuade

On Oct 11, 2016, at 3:07 PM, [redacted]@carondelet.com> wrote:

I will. It be able to forward those to you. We are a Catholic organization and that appears to conflict with your organization.

[redacted]

Sent from IPhone 7+

On Tue, Oct 11, 2016 at 12:13 PM -0500, "McQuade, Laura"
[redacted]> wrote:

Dear [redacted],

I am following up on my request from September 28th to receive staff bylaws as one of our physicians is considering applying to St. Joseph's for privileges. I look forward to hearing back from you.

Best,

Laura McQuade

President & CEO

Planned Parenthood Great Plains (PPGP)

Planned Parenthood Great Plains Votes (PPGPV)

[redacted]

[redacted]

[redacted]

[redacted]image018.png>

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www.PPGreatPlains.org | www.PPGPVotes.org

<image024.jpg>

From: McQuade, Laura
Sent: Wednesday, September 28, 2016 5:44 PM
To: [redacted]@carondelet.com>
Subject: Hospital Bylaws

Dear [redacted],

I am writing on behalf of Dr. Ronald Yeomans to request a copy of the staff bylaws for St. Joseph's Medical Center, as Dr. Yeomans is interested in what the requirements are to apply for privileges. If you could please forward any relevant credentialing documents on to me I would appreciate it.

Best,

Laura McQuade

President & CEO

Planned Parenthood Great Plains (PPGP)

Planned Parenthood Great Plains Votes (PPGPV)

[redacted]

[redacted]

[redacted]

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<image025.jpg>

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Planned Parenthood Great Plains

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EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

PLANNED PARENTHOOD OF KANSAS AND MID-MISSOURI, INC., on behalf of itself, its staff, and its patients,	)	FIRST AMENDED COMPLAINT
Plaintiff,	)	Case No. 07-4164-CV-C-ODS
v.	)	
JANE DRUMMOND, Director of the Missouri Department of Health and Senior Services, in her official capacity, et al.,	)	
Defendants.	)	

INTRODUCTION

Plaintiff, by its undersigned attorneys, brings this first amended complaint against the above-named Defendants, their employees, agents and successors in office, and in support thereof states the following:

1. The State of Missouri has amended its Ambulatory Surgical Center Licensing Law (ASCLL), to require that any facility "operated for the purpose of performing . . . five or more first trimester abortions per month" be licensed as an ambulatory surgical center. This amendment (The Act) singles out abortion as the only medical service for which the licensing requirement is triggered at five or more procedures per month (or one procedure if it is a second trimester abortion).

2. The regulatory scheme already in effect to implement the ASCLL has specific regulations for Abortion Facilities. These regulations establish two sets of physical requirements. One, the "New Construction" requirements, applies to facilities that are constructed or significantly renovated after October 25, 1987. The second, the "Pre-Existing

Facility" requirements, applies to facilities that are already in operation at the time they become subject to the ASCLL.

3. Plaintiff provides first-trimester abortions at two sites in Missouri: One location, the Brous Center, in Kansas City, provides no surgical abortions, or any other surgery, but does provide medication abortion through 8 weeks of pregnancy. The second location, the Columbia Center, in Columbia, provides abortions by a minor surgical method through 13.4 weeks of pregnancy, and by the provision of medication only, without any surgery, through 8 weeks of pregnancy, and has been doing so, except between 1999 and 2002, since April of 1987.

4. Missouri's Department of Health and Senior Services ("DHSS") has interpreted the Act as applicable to the Brous Center, thus requiring the Brous Center to be licensed as an ambulatory surgical center, even though it does not provide surgical abortions or any other type of surgery. As for the Columbia Center, DHSS has determined that in order for it be licensed it must comply with the New Facility Regulations, even though it was in operation as an abortion provider when the regulations went into effect in October 1987, as well as being an existing facility at the time the Act brought it within the ASCLL in 2007. As authorized by the regulations Plaintiff has applied for waivers of many of the most onerous and medically unnecessary regulatory requirements for both clinics, but DHSS has not responded to those requests.

5. The Act was enacted for the purpose of eliminating, or severely limiting, access to abortion in Missouri; and DHSS is applying the Act and the regulations to Plaintiff both for the purpose and with the effect, absent judicial intervention, of eliminating or severely limiting access to abortion in Missouri

6. Plaintiff has filed this action, pursuant to 42 U.S.C. 1983, claiming that: (a) the Act violates the due process clause of the Fourteenth Amendment because it was enacted for the purpose of imposing a substantial obstacle on access to abortion; (b) the Act violates the equal protection clause of the Fourteenth Amendment; (c) the Act and the regulations, as applied by DHSS to Plaintiff, violate the due process clause in that they are being applied by DHSS with the purpose and the effect, absent judicial intervention, of imposing a substantial obstacle on access to abortion; (d) the Act and the regulations, as applied by DHSS to Plaintiff, violate the due process clause in that they are not reasonably related to patient health and safety and depart from accepted medical practice; and (e) the Act and the regulations, as applied by DHSS to Plaintiff, violate the equal protection clause.

JURISDICTION AND VENUE

7. This court has jurisdiction under 28 U.S.C. §§ 1331 and 1343.

8. Plaintiff's action for declaratory and injunctive relief is authorized by 28 U.S.C. §§ 2201 and 2202.

9. Venue in this court is proper under 28 U.S.C. § 1391(b) because a substantial part of the events giving rise to this action occurred in this district and because Defendants Drummond and Nixon, in their official capacities, reside in the Central Division of the Western District of Missouri.

PARTIES

A. Plaintiff

10. Planned Parenthood of Kansas and Mid-Missouri, Inc. ("PPKM") is a not-for-profit corporation, organized under the laws of Missouri.

11. Plaintiff operates the Columbia Center in Columbia, Missouri. The Columbia Center provides general reproductive health care, including family planning services, testing and treatment for sexually transmitted infections, cervical and breast cancer screening services, pregnancy testing, and all-options counseling.

12. The Columbia Center also provides first-trimester medication and surgical abortion, and regularly provides more than five first-trimester surgical abortions per month. The Columbia Center has never been licensed as an Abortion Facility or any other type of ambulatory surgical center, as it was not required to be under the pre-Amendment version of the Act. Plaintiff brings this action on its own behalf and on behalf of its Columbia Center patients who presently or in the future desire, or may desire, abortion services in Missouri.

13. Plaintiff also operates the Brous Center in Kansas City, Missouri. The Brous Center provides general reproductive health care, including family planning services, testing and treatment for sexually transmitted infections, cervical and breast cancer screening services, pregnancy testing, all-options counseling, and medication abortion.

14. The Brous Center also provides medication abortion, and regularly provides more than five medication abortions per month. It does not provide surgical abortions, or any other surgical procedure. The Brous Center has never been licensed as an Abortion Facility or any other type of ambulatory surgical center, as it was not required to be under the pre-Amendment version of the Act. Plaintiff brings this action on its own behalf and on behalf of its Brous Center patients who presently or in the future desire, or may desire, abortion services in Missouri.

B. Defendants

15. Defendant Jane Drummond is the Director of the Missouri Department of Health and Senior Services ("DHSS"), the agency responsible for deciding applications for Surgi-Center

licensure, Mo. Rev. Stat. §§ 197.215, 197.220, as well as for adopting the reasonable rules, regulations, and standards necessary to implement Missouri's Ambulatory Surgical Center Licensing Law, Mo. Rev. Stat. § 197.225. Director Drummond is sued in her official capacity, as are her agents and successors.

16. Defendant Jay Nixon is the Attorney General for the State of Missouri. The Attorney General is charged with enforcing Missouri's Ambulatory Surgical Center Licensing Law, and has specific authority to seek injunctive and other relief for violations thereof. Mo. Rev. Stat. § 197.235. Attorney General Nixon is sued in his official capacity, as are his agents and successors.

17. Defendant Daniel Knight is the Prosecuting Attorney for Boone County, Missouri, where the Columbia Center is located. Mr. Knight is authorized to prosecute violations of the Missouri criminal law, including violations of the Act. Mr. Knight is sued in his official capacity, as are his agents and successors.

18. Defendant James Kanatzar is the Prosecuting Attorney for Jackson County, Missouri, where the Brous Center is located. Mr. Kanatzar is authorized to prosecute violations of the Missouri criminal law, including violations of the Act. Mr. Kanatzar is sued in his official capacity, as are his agents and successors.

FACTUAL ALLEGATIONS

A. The Statutory and Regulatory Framework

19. The ASCLL is contained at Sections 197.200 et seq. of Missouri's Public Health and Welfare Code. Operation of an ambulatory surgical center without a license is a Class A misdemeanor, with every day of violation constituting a separate offense. Mo. Rev. Stat. § 197.235.

20. The ASCLL requires licensure for any "public or private establishment operated primarily for the purpose of performing surgical procedures or primarily for the purpose of performing childbirths." Mo. Rev. Stat. § 197.200 (pre-amendment version). DHSS promulgated regulations to implement the ASCLL, and defined "primarily for the purpose of" (except for birthing centers) as a facility where at least 51% of the patients treated or the revenues received were for a surgical procedure. Mo. Code Regs. Ann. tit. 19 § 30-30.010 (General Surgi-Centers); § 30-30.050 (Abortion Facilities).

21. The Act is an abortion-specific amendment to the ASCLL to require that "any establishment operated for the purpose of performing or inducing any second or third trimester abortions or five or more first trimester abortions per month" be licensed as an ambulatory surgical center. Mo. Rev. Stat. § 197.200(1) (as amended by the Act).

22. Plaintiff's Columbia and Brous Centers were not licensed under the pre-Amendment version of the Act, as neither fell within the definition of ambulatory surgical center.

23. Now, as the Act has changed the trigger to 5 first trimester abortions per month, both centers are subject to the ASCLL.

24. Under pre-existing ASCLL regulations, DHSS has established three different types of ambulatory surgical centers: General Surgi-Centers, Abortion Facilities, and Birthing Centers. These regulations were attached as Exhibit D to Plaintiff's Complaint. For each of the three types of facilities, DHSS created a set of physical requirements for newly-constructed or significantly-renovated facilities ("New Construction" requirements) that do not apply to facilities already in operation when they were first required to be licensed ("Pre-Existing Facilities"). Pre-Existing Facilities have either been exempted from physical requirements altogether (in the case of General Surgi-Centers) or licensed under a parallel but more general set

of physical requirements designed specifically for Pre-Existing Facilities (in the case of Abortion Facilities and Birthing Centers).

25. DHSS's distinction between requirements for New Construction and those for Pre-Existing Facilities is in recognition of the fact that the very specific requirements that may be appropriate for facilities being constructed or significantly renovated when the regulations are already in place – and which accordingly can be designed expressly to comply with those requirements – would be inappropriate for Pre-Existing Facilities.

26. This consistent distinction between New Construction requirements and Pre-Existing Facility requirements is clear from examination of the regulations.

27. For example, when the licensing law was first enacted in 1975, DHSS established physical requirements for General Surgi-Centers that applied to "[a]ll new ambulatory surgical centers," as well as to future "additions to and remodeling of existing licensed ambulatory surgical centers," and noted that "[t]hese rules are applicable to ambulatory surgical centers which began operation or construction or renovation of a building to operate an ambulatory surgical center on any date after [the effective date of the regulations]." Mo. Code Regs. Ann. tit. 13, § 50-30 (1975 version) (attached to Plaintiff's Complaint as Exhibit E). Facilities already in operation when the licensing law was enacted were not required to comply with these physical requirements.

28. When DHSS updated the General Surgi-Center regulations in 1990, the updated regulations similarly protected Pre-Existing Facilities from having to comply with the new physical structure requirements until they were "remodeled or expanded." Mo. Code Regs. Ann. tit. 19, § 30-30.030 (1). This is the version of the regulation in effect today.

29. Similarly, when Birthing Centers first became licensed in 1995, DHSS established two sets of physical requirements: one set forth extensive physical requirements for "new birthing center construction," and the other set forth parallel but more general requirements for "[a]ny birthing center existing and in continuous operation prior to the date of the adoption of this rule." .Mo. Code Regs. Ann. tit. 19, §§ 30-30.100; 30-30.110.

30. DHSS follows the same approach when licensing Abortion Facilities. DHSS has established two sets of physical requirements for abortion facilities: one for "[n]ew abortion facilities," and a parallel but modified set for "[a]ny abortion facility in operation at the time these rules are adopted." Mo. Code Regs. Ann. tit. 19, §§ 30-30.070(2); 30-30.070(3).

31. DHSS's statutory obligation under Missouri's licensing law is to adopt regulations that "assure quality patient care and patient safety." Mo. Rev. Stat. § 197.225. Presumably, in establishing its physical requirements for Pre-Existing Abortion Facilities, DHSS made the determination that these regulations were adequate to protect maternal health and safety at facilities at which abortions represent fifty-one percent or more of the patients treated or seen.

B. The Act's Improper Purpose

32. The Act was part of a broader bill, HCS/HB1055 (attached to Plaintiff's Complaint as Ex. A). Another provision of the bill bars any entity that provides or refers for abortions from providing sexual education in the schools, and a third provision establishes an alternatives to abortion program but excludes from funding the affiliates of any organizations that provide abortion.

33. Before signing the bill into law on July 6, 2007, Governor Matt Blunt issued a written statement calling it "one of the strongest pieces of pro-life legislation in Missouri history."

Governor's Column: Treating All Life with Dignity and Respect (July 6, 2007) (attached to Plaintiff's Complaint as Ex. B).

34. Following the signing ceremony, the bill's sponsor in the House, Rep. Therese Sander, was quoted as stating in regard to the bill that her purpose in life has been to undo the damage to life done by Roe v. Wade. Barbara Shoun, Baptists Rejoice Over Pro-Life Bill Signing, the Pathway, Jul. 19, 2007 (attached to Plaintiff's Complaint as Ex. C). And the sponsor of the companion bill in the Senate, Sen. Delbert Scott, was quoted as stating that "the legislation really will save the lives of unborn children in the state of Missouri." Id.

35. DHSS has been similarly open about its view and purpose in implementing the Act. Defendant Drummond has attempted to "fire" Missouri's Attorney General as the attorney representing the executive branch in this litigation. In her letter advising the Attorney General of her intentions, Drummond wrote, "[the Act] is very pro-life while you are radically pro-abortion." Drummond 8/22/07 Letter (Plaintiff's Exhibit 5 from TRO Hearing).

36. Drummond has endeavored, instead, to be represented by the Alliance Defense Fund. The Alliance Defense Fund is a religious organization with a stated purpose of "reform[ing] American law so that all human life will be respected and protected from conception to death." http://faithandfreedomsunday.org/issues/SanctityofLife/Default.aspx (last visited August 29, 2007).

37. In correspondence with Plaintiff in July 2007, DHHS had suggested that PPKM's clinics had to be licensed under the Abortion Facility regulations.

38. Following hearing on Plaintiff's motion for a Temporary Restraining Order on August 23, and with the Brous and Columbia applications for licensure as Abortion Facilities still pending, DHSS reversed its prior position (taken before DHSS had retained the Alliance Defense

Fund) and indicated that it no longer intended to apply the Abortion Facility regulations to the licensure of abortion providers. Instead, abortion providers would have to comply with the requirements for General Surgi-Centers.

39. Compliance with the General Surgi-Center regulations would have imposed burdens far beyond, and even more medically unnecessary than, those required by the Abortion Facility New Construction requirements.

40. Moreover, if the Act were to require compliance with the General Surgi-Center regulations, then even Missouri's sole remaining abortion clinic, located in St. Louis, and already licensed under the Abortion Facility regulations, would have been required to undergo substantial renovations or close. Thus, DHSS was prepared to close down abortion services at every single provider in the state of Missouri.

41. At a hearing on August 31, on the motion of the intervenor to intervene and be granted a temporary restraining order, DHSS reversed its position once again, and stated that it no longer considers the General Surgi-Center regulations applicable to providers of abortion services.

C. The Effect of the Act on Plaintiff's Two Centers That Provide Abortions

1. The Brous Center and Medication Abortion

42. The Brous Center has been providing medication abortion since 2005. The Brous Center was already an experienced abortion provider when it began providing medication abortions, having previously provided surgical abortions from 1975 to 1998.

43. Medication abortion is a Food and Drug Administration-approved, non-invasive method of terminating an early pregnancy by oral medication. It is commonly provided out of doctors' offices and clinics nationwide.

44. Since its approval, an increasing number of women, in Missouri and throughout the country, have chosen medication over surgical abortion in early pregnancy. Many women choose medication abortion over surgical abortion because they find it less invasive and more like natural miscarriage. Also, some women choose the method because it allows the patient to feel she has more control over the process.

45. The Brous Center uses the most common combination of medications to induce abortion, mifepristone, a female hormone necessary to maintain early pregnancy, and misoprostol, a synthetic steroid used to soften and open the cervix and induce uterine contractions.

46. The patient takes mifepristone at the Brous Center, then takes the misoprostol at her home twenty-four to forty-eight hours later. The products of conception are passed at home, usually approximately four or five hours after the patient takes the misoprostol.

47. In short, medication abortion is not a surgical procedure. Rather, the abortion is accomplished through oral medication, and the products of conception passed at home.

48. Following Governor Blunt's signature of the Act on July 6, on July 18, PPKM sought clarification from DHSS that the Brous Center is not required to be licensed under the Act because it performs no surgical procedures. PPKM 7/18/07 Letter (Plaintiff's Ex. 1 at TRO Hearing).

49. On July 31, DHSS responded with a letter stating that despite the fact that the Brous Center performs no surgical procedures, the 2007 Amendment requires the Brous Center to be licensed as an ambulatory surgical center. DHSS 7/31/07 Letter (Plaintiff's Ex. 2 at TRO Hearing).

50. On August 9, the Brous Center submitted an application ("Brous Application") for licensure as an ambulatory surgical center, and specifically as an Abortion Facility, pursuant to Mo. Code Regs. tit. 19, §§ 30-30.040 – 30-30.070. Brous Application (Plaintiff's Ex. 3 at TRO Hearing).

51. For licensure under these regulations, the Brous Center would be required to comply with numerous physical requirements that were developed as safeguards for patient health and safety during surgical procedures. These requirements have no bearing on patient health or safety during the prescription of an oral medication.

52. For example, the Brous Center would be required to comply with:

- Requirements as to the length, width, ceiling height, ventilation, and surgical lights for procedure rooms – despite the fact that no "procedures" are done in the provision of medication abortion;
- Requirements as to corridor and door width that were developed to ensure ease of moving patients on a stretcher or surgical gurney – despite the fact that stretchers and surgical gurneys are not used in the provision of medication abortion;
- Scrub facilities that are knee- or foot-operated to protect sterility – despite the fact that no "scrubbing" is done to prepare for providing medication abortion;
- Recovery rooms of sufficient size to accommodate four recovery beds or recliners for each procedure room, with three feet of clear space on both sides and at the foot of each bed or recliner – despite the fact that recovery rooms are not used in the provision of medication abortion.

53. These burdensome physical requirements are medically unnecessary and not reasonably related to maternal health in the provision of medication abortion.

54. Accordingly, the Brous Center's licensure application included a request for waiver of these physical requirements, pursuant to DHSS's authority to grant requests for deviation under Mo. Code Regs. Ann. tit. 19, § 30-30.70(1). As documented in the Brous Application, the Brous Center is prepared to comply with the requirements of Mo. Code Regs. Ann. tit. 19, §§ 30-30.050 and 30-30.060 within one month, with the exception of certain requirements of § 30-30.060 that (as detailed in the Brous Application) do not appear on their face to apply to the non-surgical services provided at the Brous Center. Brous Application (Plaintiff's Ex. 3 at TRO Hearing).

55. PPKM has not yet received a response to this application.

2. The Columbia Center and Surgical Abortion

56. The Columbia Center began providing abortions in 1975, and has been providing abortions in its current location since April of 1987. With the exception of a suspension of services from 1999 to 2002 it has been providing safe and effective abortion services for over thirty years, and for twenty years at the current location.

57. The Columbia Center provides both medication and first-trimester surgical abortions. With some schedule variation, it provides these services approximately one day a week**.** Abortions and related services account for well under 51% of the Columbia Center's patients and revenues.

58. Prior to the 2007 Amendment, the Columbia Center had never been required or eligible to be licensed as a ambulatory surgical center because it is not a facility operated primarily for the purpose of performing surgical procedures. Accordingly, the Columbia Center has never been licensed as an Abortion Facility or any other form of ambulatory surgical center.

59. The only surgical procedure performed at the Columbia Center is first-trimester abortion. Abortion is one of the safest surgical procedures and is especially safe in the first trimester. First-trimester abortion requires no incisions and no general anesthesia.

60. First-trimester surgical abortion is as safe as, or safer than, many outpatient surgical procedures routinely performed in physicians' offices, such as non-pregnant dilation and curettage procedures or endometrial biopsies. However, unlike performance of an abortion, performance of other particular procedures does not subject a medical facility to the regulatory scheme unless the facility is operated primarily for the purpose of performing surgical procedures.

61. Following Governor Blunt's signature of the Act on July 6, in the same letter where PPKM sought clarification that the Act did not apply to the Brous Center, PPKM submitted an application to DHSS for licensure of the Columbia Center as an Abortion Facility ("Columbia Application") (Plaintiff's Ex. 1 to TRO Hearing). PPKM also submitted additional supporting documentation on July 23, 2007.

62. As documented in the Columbia Application and supporting documentation, the Columbia Center is prepared within one month to make the minor changes necessary to comply with the regulatory scheme's requirements for abortion facility licensure (Mo. Code Regs. Ann. tit. 19, § 30-30.050) and facility organization and management (Mo. Code Regs. Ann. tit. 19, § 30-30.060). The latter regulation includes detailed requirements on topics including the Columbia Center's governing body, bylaws, smoking policies, infection control, policies and procedures for processing laundry, personnel policies, medical staffing requirements, hospital admitting privileges or transfer agreement, record keeping, discharge instructions, informed

consent procedures, emergency tray contents, quality assurance programs, and laboratory services, and complaints procedures.

63. As documented in the Columbia Application, the Columbia Center is also prepared within one month to comply with the physical requirements for Pre-Existing Facilities . Mo. Code Regs. Ann. tit. 19, § 30-30.070(3).

64. On July 31, DHSS responded with a letter listing the ways in which the Columbia Center is not in compliance with the New Construction requirements for Abortion Facilities, thus implicitly refusing to apply the Pre-Existing Facility regulations to the Columbia Center. DHSS 7/31/07 Letter (Brownlie Dec. Ex. 2).

65. For licensure, DHSS thus would require the Columbia Center to comply with numerous additional physical requirements not otherwise imposed on Pre-Existing Facilities. These include such requirements as:

- Patient corridors at least six feet wide and door widths of at least forty-four inches – whereas the Columbia Center already complies with the requirement that corridors be sufficiently wide to allow a patient on a stretcher to be moved from any point in the facility to a street-level exit;
- Scrub facilities located outside but immediately available to the procedure room – whereas the Columbia Center already complies with the requirement that scrub facilities be located convenient to the procedure room;
- Personnel change rooms provided for each sex – whereas the Columbia Center already complies with the requirement that personnel change rooms be provided; the Columbia Center's personnel are all female; and

- A recovery room with space for at least four recovery beds or recliners with three feet clear space around each – whereas the Columbia Center already complies with the requirement that the recovery room be of sufficient size to accommodate at least four recovery beds or recliners for each procedure room, with the beds or recliners spaced to permit easy staff access to each patient;

as well as numerous other requirements.

66. The burdensome additional physical requirements DHSS has imposed on the Columbia Center's licensure are medically unnecessary and not reasonably related to maternal health. Pursuant to its statutory obligation, DHSS presumably already determined the parallel requirements for Pre-Existing Facilities to be adequate to protect maternal health and safety at facilities at which abortions represent fifty-one percent or more of the patients treated or seen.

67. Bringing the Columbia Center into compliance with the requirements for New Construction would involve significant expense. It would also require closing down at least some portions of the facility while extensive renovations proceed.

68. On August 9, 2007, PPKM submitted an application requesting waiver of these requirements for the Columbia Center, pursuant to DHSS's authority to grant requests for deviation under Mo. Code Regs. Ann. tit. 19, § 30-30.70(1).

69. PPKM has not yet received a response to this application.

70. DHSS's repeated reversals of position on which sets of regulations apply, as well as its willingness to apply regulations that are grossly medically inappropriate, are further evidence of its improper purpose in applying the regulatory scheme to Plaintiff.

D. Impact of the Act and Regulatory Scheme on Women In Missouri

71. For the Columbia Center, compliance with Act and regulatory scheme as DHSS now proposes to apply them – namely, with the New Construction Requirements for Abortion Facilities – would necessitate costly renovations that will not promote maternal health. Absent a private donor to cover the costs of extensive rebuilding, at least some portion will be passed on to the Columbia Center's patients, significantly increasing the cost of abortion services and preventing some women from obtaining an abortion. Portions of the Columbia Center would have to be shut down while these unnecessary renovations proceed, threatening its ability to offer family planning and other services to the women of Missouri. And until the unnecessary renovations were completed and approved by DHSS, the Columbia facility would be shut down entirely as an abortion service provider.

72. For the Brous Center, compliance with these physical requirements is not financially possible. Enforcement of the Act and regulatory scheme, as DHSS proposes to apply them to Brous, will force the Brous Center to stop providing abortion services permanently.

73. Enforcement of the Act and regulatory scheme, as DHSS seeks to apply them, thus will drastically reduce the availability of abortion in Missouri, shutting down the state's only abortion facilities outside of the St. Louis area. Women will be forced to travel from all corners of the state to the state's eastern border in order to obtain an abortion in Missouri.

74. This travel will increase the cost to women and delay the procedure. And if the Columbia Center is able to reopen following medically unnecessary renovations, but is forced to raise prices for abortion services in order to defray some of its expenses, the increased cost of obtaining an abortion at that facility will be prohibitive for some women, and cause delay for others.

75. Any delay in obtaining abortion is significant because gestational age is an important determinant of medical risk. Although abortion is one of the safest surgical procedures, both the morbidity (risk of major complications) and mortality (risk of death) rates for abortion increase as the pregnancy advances. And in the case of medication abortion, which is provided only early in the first trimester, if the women is unable to obtain an abortion until later in pregnancy she loses this non-surgical option.

76. The Act and the regulatory scheme, as DHSS currently proposes to apply them to Plaintiff, have the purpose and effect either to eliminate or to make more difficult and expensive the provision of abortions by Plaintiff. The Act and the regulatory scheme, as DHSS currently proposes to apply them to Plaintiff, have no medical justification. Moreover, the Act and regulatory scheme, as DHSS currently proposes to apply them to Plaintiff, single out Plaintiff for treatment that is different from all other medical providers subject to the ambulatory surgical center statute, as well as medical providers subject to other statutes and regulations relating to physical structure of their facilities.

FIRST CLAIM FOR RELIEF

77. Plaintiff hereby realleges and incorporates by reference paragraphs 1 through 76 above.

78. The Act violates Plaintiff's patients' rights of liberty and privacy guaranteed by the fourteenth amendment to the United States Constitution, in that the Act was enacted for the purpose of imposing a substantial obstacle on access to abortion.

SECOND CLAIM FOR RELIEF

79. Plaintiff hereby realleges and incorporates by reference paragraphs 1 through 78 above.

80. The Act violates Plaintiff's and Plaintiff's patients' rights to equal protection of the laws guaranteed by the fourteenth amendment to the United States Constitution

THIRD CLAIM FOR RELIEF

81. Plaintiff hereby realleges and incorporates by reference paragraphs 1 through 81 above.

82. The Act and the regulatory scheme, as DHSS currently proposes to apply them to Plaintiff, violates Plaintiff's patients' rights of liberty and privacy under the fourteenth amendment to the United States Constitution, in that the Act and regulatory scheme, as applied, would have the purpose and the effect of imposing a substantial obstacle on access to abortion, and in that, as DHSS proposes to apply them, they are not reasonably related to patient health and safety and depart from accepted medical practice.

FOURTH CLAIM FOR RELIEF

83. Plaintiff hereby realleges and incorporates by reference paragraphs 1 through 82 above.

84. The Act and the regulatory scheme, as DHSS currently proposes to apply them to Plaintiff, violates Plaintiff's and Plaintiff's patients' rights to equal protection of the laws guaranteed by the fourteenth amendment to the United States Constitution.

NOTICE OF STATE LAW CLAIMS

85. Defendants' actions are also illegal and unconstitutional under various provisions of state law. Plaintiff is foreclosed from bringing these claims in this Court pursuant to the Eleventh Amendment to the U.S. Constitution. See Pennhurst State School & Hospital v. Halderman, 465 U.S. 89, 106 (1984). Plaintiff cannot assert these claims in this Court; but Plaintiff is not waiving them. These claims include, but are not limited to:

(a) That the Act and the regulatory scheme, as DHSS proposes to apply them to Plaintiff, violate Article I, Section 2 of the Missouri Constitution; and

(b) That DHSS's proposed application of the Act and the regulatory scheme to Plaintiff is arbitrary, capricious, unreasonable, unauthorized by law, and/or an abuse of

discretion, in violation of the Missouri Administrative Procedure Act, Mo. Rev. Stat. § 536.010 et. seq.;

WHEREFORE Plaintiff requests that this Court:

1. Issue a declaratory judgment that the Act violates the rights of Plaintiff and its patients as protected by the fourteenth amendment to the United States Constitution, and is therefore void and of no effect;

2. Issue permanent injunctive relief, without bond, restraining the enforcement, operation, and execution of the Act against Plaintiff;

3. Issue a declaratory judgment that the Act and regulatory scheme, as DHSS proposes to apply them to the Brous Center, violate the rights of Plaintiff and its patients as protected by the fourteenth amendment to the United States Constitution, and is therefore void and of no effect;

4. Issue a declaratory judgment that the Act and regulatory scheme, as DHSS proposes to apply them to the Columbia Center, violate the rights of Plaintiff and its patients as protected by the fourteenth amendment to the United States Constitution, and is therefore void and of no effect;

5. Issue permanent injunctive relief, without bond, restraining the enforcement, operation, and execution of the regulatory scheme against Plaintiff by enjoining Defendants, their agents, employees, appointees, or successors from enforcing, threatening to enforce, or otherwise applying the regulatory scheme's physical requirements to the Brous Center;

6. Issue permanent injunctive relief, without bond, restraining the enforcement, operation, and execution of the regulatory scheme against Plaintiff by enjoining Defendants, their agents, employees, appointees, or successors from enforcing, threatening to enforce, or otherwise

applying the regulatory scheme's New Construction requirements for Abortion Facilities to the Columbia Center;

7. Grant Plaintiff attorneys' fees, costs and expenses pursuant to 42 U.S.C. § 1988; AND

8. Grant such further relief as this Court deems just and proper.

Respectfully submitted,

_/S/ Arthur Benson_____

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