ST. JOHN'S HEALTH
MEDICAL STAFF BYLAWS

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ST. JOHN'S MEDICAL CENTER
MEDICAL STAFF BYLAWS
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ST. JOHN'S MEDICAL CENTER
MEDICAL STAFF BYLAWS

PREAMBLE

1. Organization and Framework. These Bylaws are adopted in order to provide for the organization of the Medical Staff of St. John's Medical Center and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care provided to patients by the Hospital, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with and accountability to the St. John's Medical Center Board of Trustees, and applicants to and Members of the Medical Staff, Non-Physician Professional Staff and Allied Health Professionals.

2. Organization of Bylaws, Rules and Regulations and Policies. These Bylaws shall generally describe the organization of the Medical Staff, the prerogatives and responsibilities the Staff and each category thereof, and the basic steps and processes necessary to implement the purposes of these Bylaws and the Medical Staff. The Medical Staff and/or the Medical Executive Committee, as described herein, may adopt Rules and/or Regulations or Policies describing associated details necessary to implement such basic principles and steps, subject to the approval of the Board of Trustees. "Associated details" shall mean specific additional requirements or steps further implementing and not inconsistent with these Bylaw's general principles and processes, including but not limited to, time frames within which actions described herein must be taken and describing the proper conduct of Medical Staff organizational activities and the level of conduct and practice that is to be required of each Staff Member in the Hospital. In case of conflict between these Bylaws, Rules, Regulations and Policies, these Bylaws shall control over the Rules and/or Regulations, and the Rules and/or Regulations shall control over the Policies.

DEFINITIONS

ALLIED HEALTH PROFESSIONAL (AHP) means an individual other than a licensed physician, dentist and/or oral surgeon, podiatrist, psychologist, or chiropractor, and other than Hospital employees, who provides defined, direct patient care services under a defined degree of supervision, exercising judgment within the areas of his/her documented professional competence and consistent with applicable law. Examples of Allied Health Professionals include but are not limited to nurse practitioners, physician assistants, certified nurse midwives, and certified registered nurse anesthetists.

ALLIED MENTAL HEALTH PROFESSIONAL means any Allied Health Professional who has a professional degree in a mental health discipline and is licensed for independent practice in the state of Wyoming.

BOARD OF TRUSTEES or TRUSTEES means the Teton County Hospital District, doing business as, St. John's Medical Center Board of Trustees, also referred to as the "Board," or "Trustees."

CHIEF EXECUTIVE OFFICER means the administrator of the Hospital or other individual appointed by the Board of Trustees to act in its behalf in the overall management of the Hospital.

CHIEF OF STAFF means the chief officer of the Medical Staff elected by Members of the Medical Staff.

CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to Practitioners by the Board of Trustees, to render specific professional diagnostic and therapeutic services.

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

EXECUTIVE COMMITTEE or MEDICAL EXECUTIVE COMMITTEE means the executive committee of the Medical Staff, which constitutes the governing body of the Medical Staff.

HOSPITAL means St. John's Medical Center and Living Center, Teton County Hospital District, Jackson, Wyoming.

MEDICAL STAFF means all duly licensed physicians designated by the Board of Trustees, who have been appointed to the Medical Staff.

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

MEMBER means a physician who has been granted and maintains Medical Staff membership in good standing; a dentist and/or oral surgeon, podiatrist, psychologist or chiropractor who has been granted and maintains Non-Physician Professional Staff membership and Clinical Privileges in good standing; an Allied Health Professional who has been granted and maintains Allied Health Professional Staff membership and Clinical Privileges in good standing.

NON-PHYSICIAN PROFESSIONAL STAFF means licensed dentists and/or oral surgeons, podiatrists, psychologists and chiropractors who provide defined, direct patient care services and exercise judgment within the areas of their documented professional competence and consistent with applicable law.

PHYSICIAN means an individual with a M.D. or D.O. degree who holds a current, unrestricted license to practice medicine in the State of Wyoming.

PRACTITIONER means, unless otherwise limited, any physician, dentist and/or oral surgeon, podiatrist, psychologist, chiropractor, or allied health professional applying for, or exercising Clinical Privileges in, the Hospital.

PREROGATIVE means a participatory right granted by virtue of Staff category or otherwise, to a Staff appointee or affiliate and is exercisable subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies. STAFF means appointees to the Medical Staff, Non-Physician Professional Staff or Allied Health Professional staff.

I. NAME, PURPOSES AND RESPONSIBILITIES

I.A. NAME

The name of this organization is St. John's Medical Center Medical Staff.

I.B. PURPOSES OF THE MEDICAL STAFF

I.B.1. To be the formal organizational structure through which:

a. The benefits of membership on the Medical Staff may be obtained by individual Physicians; and

b. The obligations of Medical Staff membership may be fulfilled.

I.B.2. To serve as the primary means for accountability to the Board of Trustees for the appropriateness of the professional performance and ethical conduct of its Members, Non-Physician Professional Staff and Allied Health Professionals, and to strive toward the continual improvement of the quality and efficiency of patient care delivered in the Hospital, consistent with the state of the healing arts and the resources available.

I.B.3. To provide a means through which the Medical Staff may participate in the Hospital's policy making and planning processes.

I.B.4. To initiate, maintain, and enforce Bylaws, rules and regulations and policies for self-governance of the Medical Staff.

I.C. RESPONSIBILITIES OF THE MEDICAL STAFF

The responsibilities of the Medical Staff shall be to:

I.C.1. Measure, evaluate, improve and report to the Board of Trustees on the quality and efficiency of patient care provided by all Practitioners authorized to practice in the Hospital, through the following measures:

a. An effective mechanism in which the Medical Staff monitors, assumes leadership for and evaluates the quality of patient care and the clinical performance of individuals with delineated Clinical Privileges, identifies opportunities to improve care, identifies and solves important problems in patient care as a component of the Hospital and the Medical Staff's quality assessment and improvement process;

b. An organizational structure and mechanisms that allow ongoing monitoring of patient care practices;

c. A credentials program, including mechanisms for appointment and reappointment to the Medical Staff, and the matching of Clinical Privileges to be exercised with the verified credentials and current demonstrated performance of the applicant, Medical Staff Member, Non-Physician Professional Staff Member or Allied Health Professional;

d. A utilization review program to provide for the allocation of inpatient medical and health services to patients in need of them.

I.C.2. Recommend to the Board of Trustees action with respect to appointments, reappointments, Staff category and clinical service assignments, Clinical Privileges, specified services for Allied Health Professionals, and corrective action.

I.C.3. Recommend to the Board of Trustees programs for the establishment, maintenance, continuing improvement and enforcement of professional standards in the delivery of health care within the Hospital.

I.C.4. Report, in writing, at specific intervals, to the Board of Trustees of conclusions, recommendations, actions taken, and the results of actions taken through channels established by the Medical Staff.

I.C.5. Initiate and pursue corrective action with respect to Practitioners, when warranted.

I.C.6. Develop, administer, recommend amendments to, and seek compliance with, these Bylaws, Medical Staff rules and regulations, and other Hospital policies.

I.C.7. Assist the Board of Trustees in identifying community health needs and in setting appropriate organizational goals and implementing programs to meet those needs and goals.

I.C.8. Exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

II. MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES QUALIFICATIONS

II.A. CLINICAL PRIVILEGES AND MEDICAL STAFF MEMBERSHIP QUALIFICATIONS

II.A.1. Medical Staff membership is a privilege which must be applied for and which shall be extended only to professionally competent Physicians who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to the Medical Staff shall not entitle any Medical Staff Member to exercise any specific Clinical Privilege, which must be separately applied for and granted, as set out in these Bylaws.

II.A.2. Physicians, dentists and/or oral surgeons, podiatrists, psychologists, chiropractors and other licensed independent practitioners meeting the requirements described in this Article may be eligible to be granted Clinical Privileges, within the scope of the individual's licensure, training and competence, to treat patients at the Hospital.

II.B. PHYSICIAN QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

II.B.1. 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 provide evidence of the following (the "Threshold Eligibility Criteria"):

a. Government issued identification and proof of either US citizenship or evidence of status as a lawful permanent resident of the US;

b. Current unrestricted licenses to practice relevant profession in Wyoming or evidence of pending application for Wyoming licensure (i.e. medicine, dentistry, podiatry, psychology, physical therapy, etc.);

c. Graduate degree in applicable profession;

d. Training in applicable profession; if physician, evidence of completion of an ACGME or AOA approved residency;

e. Board certified or eligible for board certification in relevant professional specialty under then current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) guidelines.

f. No history of the following actions at any organization: (1) involuntary termination of Medical Staff membership; (2) any non-administrative suspension, revocation, denial of renewal, surrender of Medical Staff

membership; or, (3) relinquishment of membership, failure to reapply for, or resignation of Medical Staff membership while under investigation;

g. No current pending investigation by a state licensing board or organization medical staff;

h. Current DEA and state controlled substance registration in any state, if applicable to professional specialty;

i. Professional liability insurance coverage or evidence of eligibility to obtain Wyoming professional liability insurance;

j. Seeking Clinical Privileges for diagnostic and therapeutic services which the Hospital is equipped to provide (as described in a proposed practice plan); and,

k. Never been, and not currently, excluded, precluded or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program as verified by review of the OIG, GSA, and state exclusion list.

II.B.2. General Qualifications

Practitioners must continuously meet the following qualifications, standards, and requirements to obtain, and maintain Medical Staff appointment and/or Clinical Privileges. Practitioners must be:

a. Adequately experienced, educated, trained, professionally competent, possess good judgment and adequate physical and mental health, so as to demonstrate to the satisfaction of the Medical Executive Committee and the Board of Trustees that the individual is professionally and ethically competent to carry out any and all of the Clinical Privileges requested.

b. Determined, on the basis of three current documented peer references, National Practitioner Data Bank review, and/or observed practices, to adhere to the ethics of the individual’s profession, to be able to work cooperatively with others (including Members, AHPs, Hospital employees, Hospital management, patients and patients’ families) in the care of patients, to refrain from disruptive behavior that interferes with patient care or the orderly operation of the Hospital, and to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff and the Board of Trustees.

c. Willing to adhere to the ethics of their profession and respective specialty, including the American Medical Association Principles of Medical Ethics, these Bylaws, and the Medical Staff Code of Conduct.

d. Protected by professional liability insurance in the amount required by the Hospital and with an insurer acceptable to the Hospital.

e. Board Certified within the period of time required by the ABMS or AOA after becoming Board eligible (or within five (5) years of initial Medical Staff appointment, whichever is earlier). If the Practitioner fails to become Board certified within the required time frame, then the Practitioner will be ineligible for reappointment for failure to meet the minimum requirements for being granted Clinical Privileges, without right of any hearing or appeal rights described in these Bylaws. Exceptions to the above may be made only by the Board in its sole discretion, after a joint conference with the Medical Staff, upon determination that the physician demonstrates an equivalent competence in the areas of requested Clinical Privileges.

f. Participation in continuing medical education relevant to the individual's Clinical Privileges as determined by the Credentials Committee.

II.B.3. No Physician shall be entitled to Medical Staff membership or granted particular Clinical Privileges merely by virtue of licensure to practice medicine in this or in any other state; certification, fellowship or membership in any professional organization, specialty body or society; board-eligibility or certification; or medical staff membership or clinical privileges held at another health care facility.

II.C. BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

The ongoing responsibilities of each Member of the Medical Staff include:

II.C.1. Providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital and the physician's professional association;

II.C.2. Abiding by the Medical Staff Bylaws and Medical Staff rules and regulations by applicable Rules and Regulations or policies approved by the Board of Trustees;

II.C.3. Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed on the Member by virtue of Medical Staff membership, including committee assignments;

II.C.4. Preparing and completing in timely fashion complete and accurate medical records for all the patients for whom the Member provides care in the Hospital;

II.C.5. Abiding by the lawful ethical principles of the Medical Staff Member's applicable professional association, the American Medical Association Principles of Medical Ethics and the Medical Staff Code of Conduct;

II.C.6. Aiding in any Medical Staff approved educational programs for Staff Members, nurses and other personnel;

II.C.7. Working cooperatively with Members, nurses, Hospital Administration and others so as to promote high quality patient care;

II.C.8. Participating on the Hospital's Emergency Service call schedule in accordance with Hospital policies and procedures developed in consultation with the Medical Staff. Participation on the call schedule is a responsibility, not a right, of Medical Staff membership.

II.C.9. Providing continuous care and supervision, either personally or by making appropriate arrangements for coverage, for his or her patients in the Hospital as determined by the Medical Staff;

II.C.10. Refusing to engage in improper inducements for patient referral;

II.C.11. Participating in continuing education programs as determined by the Medical Staff;

II.C.12. Participating in peer review and other quality improvement activities;

II.C.13. Discharging such other Staff obligations as may be lawfully established from time to time by the Medical Executive Committee or the Board of Trustees; and

II.C.14. Adhering to a professional code of conduct which shall require individuals appointed to the Medical Staff to relate in a positive and professional manner to other healthcare professionals, and to cooperate and work collegially with the Medical Staff leadership and Hospital management and personnel. Professional conduct shall include, but not be limited to, the ability to relate to others in a civil, collegial, and courteous manner. Professional conduct shall also include, but not be limited to, each Member's obligation to present himself or herself at the Hospital physically, emotionally, and mentally capable of providing safe and competent care to patients at all times, and to self-report any illness and/or impairment that would interfere with this obligation.

II.D. NON-PHYSICIAN PROFESSIONAL STAFF PRACTITIONER CLINICAL PRIVILEGES REQUIREMENTS

II.D.1. Non-Physician Professional Staff Practitioners applying for Clinical Privileges only shall be required to meet the minimum requirements for such Clinical Privileges, which shall include those requirements described in Section II.B. as applicable to such Practitioner's licensure, scope of practice and profession.

II.D.2. All Medical Staff Members and Practitioners shall, as a condition of appointment and/or grant of Clinical Privileges, act at all times in an ethical, professional, and courteous manner in accordance with the mission and philosophy of the Hospital.

II.E. NONDISCRIMINATION

Medical Staff appointment and/or Clinical Privileges grants will be made without regard to religion, race, creed, color, national origin, sexual orientation, gender, age or disability except as necessary to safeguard the health or safety of the applicant or others.

II.F. DURATION OF MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGE GRANTS

Initial Medical Staff appointments and/or Clinical Privileges grants shall be for one year. Reappointments to the Medical Staff, and Clinical Privilege renewals, shall be for no more than twenty-four (24) consecutive calendar months. The Medical Staff may recommend appointment, reappointment, initial grant or renewal for any shorter period, in its sole discretion.

III. MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES PROCESS

The processes described in this Article shall be used for all applications for Medical Staff membership, and grants of Clinical Privileges for all Physician and Non-Physician Professional Staff applying for Clinical Privileges. Individuals who are not Physicians or Non-Physician Professional Staff may apply for permission to treat patients in the Hospital, within their scope of licensure and profession, through the Hospital's human resources department.

III.A. PRE-APPLICATION

Upon request for an application for Medical Staff membership and/or Clinical Privileges, the Medical Staff Services Office shall provide a potential applicant with a pre-application form. A potential applicant for Medical Staff membership and/or Clinical Privileges shall submit a pre-application form indicating that he or she satisfies the Threshold Eligibility Criteria listed in Section II.B.1. of these Bylaws for Medical Staff membership and/or Clinical Privileges as a prerequisite to being provided an application for Medical Staff membership and Clinical Privileges (an "Eligible Applicant"). The pre-

application form shall attach a complete set of Medical Staff Bylaws and Rules and Regulations. After a potential applicant submits a pre-application form, the Chief of Staff may offer a meeting with the potential applicant. The meeting may include the potential applicant, Chief of Staff, Chief Executive Officer, and/or applicable specialty group leaders. The topics discussed shall be limited to the applicant process and information contained in the pre-applicant form. The potential applicant will be notified by the Medical Staff Services Office if the potential applicant has not shown they meet the Threshold Eligibility Criteria for Medical Staff membership and/or Clinical Privileges.

III.B. INITIAL APPOINTMENT

III.B.1. Submission of Application

The Medical Staff Services Office shall provide Eligible Applicants with an application for Medical Staff appointment and Clinical Privileges, which includes the Medical Staff Application Policy. Applications shall be completed in an electronic form provided by the Medical Staff Services Office, which shall require a detailed statement of qualifications and references by the Eligible Applicant. At the time of the application submission, Eligible Applicant shall provide any additional information relevant or necessary to conduct a complete consideration and review of the application.

III.B.2. Credentials Committee

Once determined to be complete by the Medical Staff Services Office, an application will be placed on the agenda of the next Credentials Committee meeting. The Credentials Committee will review the application to determine if the Eligible Applicant meets the qualifications for appointment to the Medical Staff as set forth in Section II.B. of these Bylaws and standards for the requested Clinical Privileges. The Credentials Committee may request the applicant provide additional information. The Credentials Committee will then make a positive or adverse recommendation to the MEC, based on the application and any information provided by the Eligible Applicant.

a. POSITIVE RECOMMENDATION. If the Credentials Committee recommendation is positive for the Eligible Applicant, the positive recommendation shall be provided to the MEC for consideration at its next regularly scheduled meeting.

b. ADVERSE RECOMMENDATION. If the Credentials Committee is considering an adverse recommendation for the Eligible Applicant, then it (shall/may) request a meeting with the Eligible Applicant and representatives of the Credentials Committee in order to provide the Eligible Applicant an opportunity to provide additional information.

    (i) If after such meeting the Credentials Committee recommendation is adverse to the applicant, or if the Eligible Applicant declines or fails to appear at such meeting, a report will be generated including a statement of the evidence considered by the Credentials Committee which formed the

basis of the adverse recommendation and listing of the Medical Staff Bylaws, Rules and Regulations, and/or Policies, or Hospital Bylaws or Policies or laws that were not met and a description of how each was not met.

(A) The Eligible Applicant will be provided the above noted report and asked to provide a written response to the Credentials Committee within 10 days for consideration.

III.B.3. (B) After the Eligible Applicant has responded to Credentials Committee report, or in the absence of a response, the Credentials Committee report and positive or adverse recommendation shall be provided to the MEC for consideration at its next regularly scheduled meeting. **MEC**

A summary of the completed application, together with the Credentials Committee's recommendation(s), shall be reviewed at the next regularly scheduled MEC meeting. The MEC shall make a positive or adverse recommendation to the Governing Board on the basis of the application, accompanying information, and previous recommendations.

a. POSITIVE RECOMMENDATION. If the MEC's recommendation is positive for the Eligible Applicant, the positive recommendation shall be provided to the Board for consideration at its next regularly scheduled meeting.

b. ADVERSE RECOMMENDATION. If the MEC is considering an adverse recommendation, then it (shall/may) first request a meeting with the Eligible Applicant in order to afford the Eligible Applicant an opportunity to provide additional information. If after such meeting the MEC's recommendation is adverse to the applicant, or if the Eligible Applicant declines or fails to appear at such meeting, the Chief of Staff shall promptly so notify the applicant by mail, return receipt requested, of the adverse recommendation and the applicant's right to a hearing on the adverse recommendation under Article VIII of these Bylaws.

(i) If the MEC recommendation is adverse to the applicant, the Credentials Committee report will updated to reflect the evidence considered by the MEC which formed the basis of the adverse recommendation including a listing of the Medical Staff Bylaws, Rules and Regulations, and/or Policies, or Hospital Bylaws or Policies or laws that were not met and a description of how each was not met. If, after requesting a hearing or appeal, the applicant fails without good cause in the reasonable discretion of the MEC, to personally attend and proceed at such hearing, such failure shall be deemed a voluntary acceptance of the adverse recommendations or action involved.

III.B.4. **Deferral**

Either the Credentials Committee, the MEC, or both, may defer consideration of an application as reasonably necessary. The committee deferring consideration shall notify the applicant of the deferral.

III.B.5. Governing Board

a. A summary of the completed application and the recommendation of both the Credentials Committee and the MEC, shall be considered at the next regularly scheduled Governing Board meeting after the MEC determines its recommendation. Unless the MEC's recommendation was adverse to the Eligible Applicant and the Eligible Applicant has requested a hearing under these Bylaws. In such case, the hearing and appeals process described in these Bylaws shall control.

b. All Medical Staff appointments, and Clinical Privilege grants, shall be made by the Governing Board based solely on the application, the materials provided, and the recommendation of the MEC, or as described in the hearing and appeals process. The Board's approval of an application for Medical Staff membership shall include placement of the Medical Staff Member in the appropriate category.

c. The Chief Executive Officer shall promptly notify the Eligible Applicant of the approval or denial of his or her application, in whole or in part. A copy of this notification letter shall be retained in the Eligible Applicant's file.

d. A completed application for an Eligible Applicant shall be either accepted or rejected within a reasonable period of time of being first reviewed at a meeting of the Credentials Committee, subject to the requirements of the hearing and appeals process (to the extent applicable).

III.B.6. Appointment Period

The initial Medical Staff appointment and/or granting of Clinical Privileges shall be for a period of twelve (12) months.

III.B.7. Assignment of Preceptor

If deemed appropriate, the requirement of a preceptor will be recommended by the Credentials Committee and/or Medical Executive Committee and submitted to the Governing Board for consideration with the completed application. Should a preceptor be required, the preceptor should be of the same specialty if reasonably feasible.

III.B.8. Orientation

All Medical Staff Members and Practitioners shall receive a general Medical Staff orientation immediately upon appointment and/or initial grant of Clinical Privileges, which will include appropriate training for the Hospitals electronic health record system, an Informational Packet and an opportunity to tour the Hospital.

III.C. Reappointment

Medical Staff Members are reappointed, and Practitioner's Clinical Privileges renewed, at least every three (3) years. Reappointment to the Medical Staff, and/or renewal of Clinical Privileges, shall be made only after review of the Physician Member's or Practitioner's previous three years' activities.

III.C.1. Request

A Request for Reappointment/Renewal (a "Request") shall be sent to each Member due for reappointment and/or renewal, at least 60 days before the Member's appointment or Clinical Privileges expire.

III.C.2. Reappointment/OPPE Activity Summary

a. The Medical Staff Office shall create a confidential OPPE Quality Activity Summary for each Member, including quality assessment and improvement data with information relevant to the reappointment/renewal, and present it to the Credentials Committee.

b. The Reappointment/OPPE Activity Summary shall include enough data, generated by the Member's use of his or her Clinical Privileges during the most recent grant period, for the Credentials Committee to evaluate the Member's current competence to exercise the requested Clinical Privileges. The Committee may ask the Member to provide documentation of competency for any Clinical Privilege for which there is insufficient data to make a positive finding that the Member is currently competent to exercise. The lack of patient encounters may constitute grounds for suspension of medical staff privileges, ineligibility for reappointment or a change in Medical Staff status.

c. The reappointment process shall include, at a minimum, primary source verification of current licensure, any required certifications, current WY DEA certificate (if applicable), review of involvement in any professional liability action, and receipt of database profiles from the NPDB and OIG Medicare/Medicaid Exclusions.

III.C.3. Reappointment/Renewal Process

The Request shall be considered in the same manner as the initial application for appointment and/or request for grant of Clinical privileges, as described above in Section III.B.

III.C.4. Governing Board Unable to Meet

If the Governing Board is unable to meet to consider the Member's application for membership reappointment and/or renewal of Clinical Privileges before expiration, such membership and/or Clinical Privileges shall be renewed without a change in current status, only until the next Governing Board meeting. This renewal shall not occur if the expiration is the result, in whole or in part, of the Member's failure to follow the Medical Staff's reappointment process.

III.D. BURDEN ON APPLICANT TO SUBMIT COMPLETE APPLICATION OR REQUEST

Each applicant, whether for initial Medical Staff appointment and/or granting of Clinical Privileges, or for reappointment or renewal of such, shall be solely responsible for completing the application or request (as applicable), and producing adequate information for a proper evaluation of his or her competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications and satisfying requests for information.

1. The applicant's failure to provide all required information or otherwise sustain this burden, or falsification or misrepresentation of any information in any such application or request, shall be grounds to stop processing or considering the application or request, deny the application or request, or deem the application or request incomplete. Neither the Medical Staff Office nor the Medical Staff will have any obligation to process an incomplete application or request.
2. Applications begun, but that remain incomplete for an extended period of time due to inaction by the applicant shall be deemed incomplete and abandoned in the reasonably exercised discretion of the MEC, and the Eligible Applicant shall be deemed to have forfeited any application fees paid.
3. Requests not completed by expiration of the Member's appointment and/or grant of Clinical Privileges shall result in expiration of the Member's appointment and/or Clinical Privileges, and forfeiture of any dues or fees paid.

III.E. LEAVE OF ABSENCE

III.E.1. Leave Status

If any Member anticipates that he or she will be absent from the Hospital for three (3) months or more due to illness, postgraduate study, military service, extended vacation,

or other reasons may request a voluntary leave of absence from the Staff by submitting a written request to the Medical Executive Committee stating:

a. The approximate period of leave desired, which may not exceed twelve (12) consecutive months;

b. Sufficient information for the Medical Executive Committee to determine that the leave of absence, as opposed to the Member resigning his or her Staff membership and/or Clinical Privileges, is justified; and

c. Sufficient information to determine whether a statement under Section III.E.4. is required if the Member returns.

And, when appropriate:

d. A description of the benefits the Member expects to gain by taking the leave of absence, and the benefits to the Staff of the Member being granted a leave of absence;

e. A description of the medical education, practice opportunities or other medical information, the Member expects to participate in or obtain during the leave, so that the Medical Executive Committee may determine what conditions the Member must satisfy prior to returning from leave;

The Medical Executive Committee may grant the requested leave of absence at its discretion. During the period of the leave, the Member shall not: exercise Clinical Privileges at the Hospital, be subject to OPPE, be entitled to exercise any of the rights of membership, or be required to fulfill any of the responsibilities or obligations of membership, including the obligation to maintain professional liability insurance. The obligation to submit a completed reappointment request and pay dues, if any, shall continue, unless waived by the Medical Executive Committee.

III.E.2. If a Member on leave fails to timely submit an application for continuation of his or her membership, as described above, his or her membership shall be considered voluntarily relinquished and expire at the end of the maximum twelve (12) month leave of absence.

III.E.3. <u>Termination of Leave</u>

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Member shall notify the Medical Executive Committee in writing of the date his or her leave will terminate, and that he or she will return from the leave of absence. The Staff Member shall submit a summary of relevant activities during the leave and warrant that all conditions imposed by the Medical Executive Committee on the Member for the leave have been fulfilled. The Medical Executive Committee may upon receipt of the notice require the Member to submit to an interview, and may decline to accept the notification if it determines that the Member has not satisfied all conditions required for

return. Upon termination of leave of absence, the Member may be subject to FPPE including, proctoring, co-management or other such observation or supervision as the Medical Executive Committee shall, in its discretion, determine is necessary to ensure patient safety, before the Member resumes the independent exercise of any Clinical Privileges. Such observation and/or supervision measures shall not be in effect for more than twenty nine (29) days unless the Member is entitled to such hearing and appeal rights as are described in these Bylaws.

III.E.4. Failure to Request Reinstatement

Failure to notify the Medical Executive Committee of termination of a leave of absence shall be deemed a voluntary resignation and shall result in expiration of Staff membership. A Member whose Staff membership expires or is deemed to have voluntarily resigned shall not be entitled to the hearing and/or appeal rights set out in Section VIII. Except as set out in a policy approved by the Medical Executive Committee, a request for continuation of or reappointment to membership subsequently received from a former Member whose membership has expired or has been deemed to have voluntarily resigned, shall be submitted and processed in the manner specified for applications for initial appointments.

III.E.5. Reinstatement after Leave for Reasons of Health or Disability

A Member who requests reinstatement after a leave for health or disability reasons shall submit a health statement affirming that he or she is fit to safely and competently exercise the requested Clinical Privileges, in accordance with Section II.B. The Medical Executive Committee may request a medical examination by an examiner of its selection, to be paid for by the Member. The Member who requests reinstatement agrees that the examiner may provide pertinent medical information to the Medical Executive Committee or its designee, and shall execute all reasonably necessary documentation as is requested by the Medical Executive Committee to affect such permission and/or agreement, including but not limited to authorizations to comply with HIPAA, and waiver of physician-patient privilege.

III.F. CONFIDENTIALITY OF INFORMATION

Any and all applications, interviews, meetings, requests, actions and/or decisions not to act pursuant to this Section are deemed to be in furtherance of the purposes and requirements of the Health Care Quality Improvement Act of 1986 (42 U.S.C. §§ 11101 et. seq.) and Wyoming law (W.S. §§ 35-2-910 and 35-17-101 to 106). All such activity, and the materials related thereto, are considered confidential and cannot be disclosed to persons outside the Hospital or its Medical Staff pursuant to, among others, the Health Care Quality Improvement Act of 1986 and Wyoming law (W.S. §§ 16-4-203, 35-2-609, 35-2-910, and 35-17-101 to 106), unless otherwise required or permitted by law.

III.G. REQUIRED AGREEMENT

Upon submission of an initial application or application for reappointment, an individual that he or she has received and read the current Medical Staff Bylaws and Rules and Regulations and agrees to be bound by them, including any amendments to Bylaws, Rules and Regulation as may be adopted. Eligible Applicant acknowledges that the due process provisions contained in these Bylaws are governed by the Wyoming Administrative Procedure Act; however, in the event of a conflict between the Wyoming Administrative Procedure Act and Bylaws, these Bylaws shall control.

IV. CATEGORIES OF MEMBERSHIP

IV.A. CATEGORIES

The categories of the Medical Staff shall include the following: active, courtesy, consulting, provisional, honorary and preceptee. At each time of reappointment, the Member's Staff category shall be determined.

IV.B. ACTIVE STAFF

IV.B.1. Qualifications

The active Staff shall consist of Physician Members who:

a. Meet the general qualifications for membership set forth in Section II.B;

b. Attend at least the required total of applicable committee and general Medical Staff meetings each year. Active Staff Members who do not attend at least 50% of the total applicable committee and General Medical Staff meetings each year will be ineligible to vote, as provided at Section XII.D.3.

c. Have satisfactorily completed their designated term in the provisional Staff category; and

d. Regularly admit, or are otherwise regularly involved in the care of, Hospital patients (a minimum of 11 patient contacts per year).

IV.B.2. Prerogatives

Except as otherwise provided, an active Staff Member shall be entitled to:

a. Exercise such Clinical Privileges as are granted pursuant to Article III;

b. Attend and vote on matters presented at general and special meetings of the Medical Staff and of the committees of which he or she is a member; and

c. Hold Staff office and serve as a voting member of committees to which he or she is duly appointed or elected by the Medical Staff or a duly authorized representative thereof.

IV.C. COURTESY STAFF

IV.C.1. Qualifications

The courtesy Staff shall consist of Physician Members who elect to become Members of the courtesy Staff and have attained the age of sixty (60) years plus a minimum of ten (10) years as Members of the active Medical Staff or have served on the active Medical Staff for twenty (20) years, or Physician Members who:

a. Meet the general qualifications for membership set forth in Section II.B;

b. Have a minimum of three and maximum of ten patient contacts per year at the Hospital;

c. Are members in good standing of the active medical staff of another hospital requiring quality assurance activities of a substance and character similar to those in the Hospital;

d. Have satisfactorily completed their designated term in the provisional Staff category; and

e. Practice in an area or specialty that is not represented on the Staff or is otherwise needed at the Hospital.

IV.C.2. Prerogatives

Except as otherwise provided, the courtesy Staff Member shall be entitled to:

a. Exercise such Clinical Privileges as are granted pursuant to Article III;

b. Attend meetings on the Medical Staff, including educational programs; and

c. Serve on appropriate Medical Staff committees at the discretion of those committees, and if servicing on a Medical Staff committee, vote on committee matters at the discretion of the committee.

IV.C.3. Limitations

a. Courtesy Staff Members that exercise Clinical Privileges at the Hospital may, after review by the Medical Executive Committee, be required to seek appointment to an alternative, appropriate Staff category.

b. Courtesy Staff Members shall have no right to vote at meetings of the entire Medical Staff;

c. Courtesy Staff Members shall not be eligible to hold office in the Medical Staff organization; and

d. Courtesy Staff Members shall not be eligible to vote for Medical Staff officers or representatives to the Medical Executive Committee.

IV.D. CONSULTING STAFF

IV.D.1. Qualifications

The consulting Staff shall consist of Physicians who:

a. Meet the Medical Staff membership qualifications set forth in Section II.B;

b. Provide medical or surgical consultation for Medical Staff Members in other Medical Staff categories, which may include intraoperative consultation.

IV.D.2. Prerogatives

The consulting Staff shall be entitled to:

a. Exercise such Clinical Privileges as are granted pursuant to Article III; and

b. Attend meetings of the Medical Staff, including open committee meetings and educational programs.

IV.D.3. Limitations

a. Consulting Staff Members who provide direct patient care or regularly assist at surgery may, after review by the Medical Executive Committee, be required to seek appointment to an alternative, appropriate Staff category.

b. Consulting Staff shall generally not be granted admitting privileges at the Hospital. Exceptions to this general prohibition are as follows:

   (i) In extraordinary situations where the needs of the Hospital and patient care warrant, admitting privileges may be granted to consulting Staff but only upon the recommendation of the Medical Executive Committee.

   (ii) Emergency Department physicians admitted only to the Consulting Medical Staff may be granted privileges sufficient to admit and care for a patient, following consultation with the Physician who will attend the patient in the Hospital, until that attending Physician arrives at the Hospital to assume care of the patient; and

(iii) Members of the consulting Staff who regularly provide locum tenens coverage for Members of the active Medical Staff may be granted admitting privileges upon the recommendation of the Medical Executive Committee.

c. Consulting Staff Members have no right to vote at meetings of the Medical Staff or Medical Staff committees (except as permitted by individual committees).

d. Consulting Staff Members are not eligible to hold office in the Medical Staff organization.

e. Consulting Staff Members are not eligible to vote for Medical Staff officers or representatives to the Medical Executive Committee.

IV.E. PROVISIONAL STAFF

IV.E.1. Qualifications

The provisional Staff shall consist of Physicians who:

a. Meet the general Medical Staff membership qualifications set forth in Sections II.B; and

b. Have not previously been appointed to the active Medical Staff and are interested in serving on the active Medical Staff.

IV.E.2. Prerogatives

The provisional Staff Member shall:

a. Admit patients and exercise such Clinical Privileges as are granted pursuant to Article III;

b. Be appointed to a specific service;

c. Attend meetings of the Medical Staff, serve on committees to which the Member has been appointed, and attend educational programs; and

d. Vote on matters raised before the Medical Staff committees to which the Member has been appointed.

IV.E.3. Limitations

a. Provisional Staff Members are not eligible to hold office in the Medical Staff organization.

b. Provisional Staff Members are not eligible to vote for Medical Staff officers or representatives to the Medical Executive Committee.

c. Provisional Staff Members are not eligible to vote on matters that are required to come before the entire Medical Staff.

IV.E.4. Term of Provisional Staff Status

A Member shall remain on the provisional Staff for a period of one year, unless that status is extended by the Medical Executive Committee for an additional period of up to one (1) year, on a determination of good cause, which determination shall not give rise to the right to a hearing pursuant to Article VIII.

IV.E.5. Action at Conclusion of Provisional Staff Status

a. If the provisional Staff Member has satisfactorily demonstrated his or her ability to exercise the prerogatives of Medical Staff membership, and otherwise appears qualified for continued Medical Staff membership, the Member shall be eligible for placement in the appropriate Staff category, upon recommendation of the Medical Executive Committee; and

b. In all other cases, the Medical Executive Committee shall make its recommendation to the Board of Trustees regarding a modification or termination of Medical Staff membership.

IV.F. PRECEPTEES

IV.F.1. Qualifications

Preceptees shall be individuals who:

a. Are medical students, interns, residents and fellows training in medicine or another health-related field;

b. Are attending clinical rotations at the Hospital; and

c. Work and study under the supervision of a preceptor who is a Member of the Medical Staff as part of, and in conjunction with, an ongoing, training program approved by the Medical Executive Committee.

IV.F.2. Limitations

A preceptee may perform only such services as are appropriate for his or her level of training as defined by his or her academic program.

IV.G. EMERITUS/HONORARY STAFF

IV.G.1. Qualifications

The Emeritus/Honorary Staff shall consist of Physicians who no longer practice at the Hospital but who are deemed deserving, by virtue of their outstanding reputation, noteworthy contribution to health and medical sciences, or their previous long-standing service to the Hospital.

IV.G.2. Limitations

Emeritus/Honorary Staff shall have no Clinical Privileges, and shall not be eligible to admit patients to the Hospital. They may attend Medical Staff committee meetings, but may not vote at Medical Staff or other committee meetings or hold office. They shall not be required to attend Medial Staff meetings, complete reappointment applications, or pay Staff dues. Practitioners with Emeritus/Honorary status will be invited and welcome to attend educational and social functions of the Hospital and Medical Staff.

IV.H. LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws and by the Medical Staff or service rules and regulations.

IV.I. MODIFICATION

On its own or pursuant to a request by a Member under Section III.C, the Medical Executive Committee may recommend a change in the Medical Staff category of a Member consistent with the requirements of the Bylaws.

V. CLINICAL PRIVILEGES

V.A. EXERCISE OF PRIVILEGES

V.A.1. Except as otherwise specified herein, no person (including persons engaged by the Hospital in medico-administrative positions) shall admit or provide medical care, treatment or health-related services to patients in the Hospital unless and until that person applies for and receives a grant of Clinical Privileges sufficient to do so. Except as otherwise provided in Sections V.F. (Emergency Privileges) and V.G. (Disaster Privileges), a Staff Member shall be entitled to exercise only those Clinical Privileges at the Hospital specifically granted to him or her by the Board of Trustees.

V.A.2. Said Clinical Privileges must be Hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in Wyoming and consistent with any restrictions thereon. Clinical Privileges shall be granted and exercised subject to these Bylaws, and any applicable rules and regulations, policies and procedures, of the Medical Staff.

V.B. EVALUATION UPON GRANT OF CLINICAL PRIVILEGES

Each Staff Member granted Clinical Privileges hereunder shall undergo a period of focused professional practice evaluation (FPPE) as described in a policy approved by the Medical Executive Committee immediately after such Clinical Privileges are granted. The purpose of the FPPE shall be to evaluate the Member's proficiency in the exercise of Clinical Privileges granted. The FPPE shall follow the frequency and format as described in the policy, and shall apply to all Members' initial grant of Clinical Privilege(s), and any grant of subsequent privilege(s).

V.C. DELINEATION OF PRIVILEGES IN GENERAL

V.C.1. Requests

Applications for initial granting or modification of Clinical Privileges shall be processed as described in Article III. Each application for Staff appointment and reappointment under Article III must contain a request for the specific Clinical Privilege(s) desired by the applicant or Member. A request by a Member for a modification of Clinical Privileges may be made at any time, but such requests must be supported by documentation of licensure, training, experience, qualifications, ability and competence to exercise such privileges.

V.C.2. Modification of Privileges

A Staff Member who seeks modification of Clinical Privilege(s) previously granted may submit such a request at any time on a form developed by the Medical Executive Committee, except that such applications for additional privileges may not be filed within six (6) months of the time a similar request has been denied. The request must be accompanied by an acceptable statement of the basis for the request and data supporting the request, including documentation of appropriate training and experience.

V.C.3. Basis for Determination of Privileges

Requests for Clinical Privileges (whether new or continued) shall be evaluated on the basis of the applicant or Member's education, training, experience, demonstrated professional competence and judgment, observed clinical performance, performance of a sufficient number of procedures on an ongoing basis to maintain the Staff Member's skills and knowledge to exercise such Clinical Privileges. Such evaluation will include any professional liability claims, adverse actions by other hospitals or professional entities, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate and which may be set out in Medical Staff policies and/or procedures. Privilege determinations may also consider, but not be exclusively based on, pertinent information concerning clinical performance obtained from other sources, especially other

institutions and health care settings where a Member exercises clinical privileges.

V.C.4. Ongoing Professional Practice Evaluation

a. All Medical Staff Members granted Clinical Privileges (other than the privilege to refer and follow patients) shall be subject to ongoing professional practice evaluation (OPPE) during the Member's term of appointment and in accordance with such policies approved by the Medical Executive Committee.

b. The Medical Executive Committee, by policy, shall determine a minimum number of patient encounters a Staff Member must perform within a given period required for Staff Members to qualify to undergo OPPE. If any Staff Member fails to meet the required minimum number of patient encounters in the time period prescribed, he or she may be determined to lack sufficient data on which to perform OPPE, in which case Member maybe rendered ineligible for appointment.

V.D. TEMPORARY CLINICAL PRIVILEGES

V.D.1. Circumstances Warranting Temporary Clinical Privileges

a. Temporary Clinical Privileges may be granted to a new applicant to meet an urgent patient care need, provided the applicant has clinical privileges at another hospital, or successfully completed a residency/fellowship within the last twelve (12) months, and the procedure described in Section V.D.2 has been followed.

b. Temporary Clinical Privileges may be granted to a preceptor from another organization, for the purpose of providing specific training to one or more Members of the Medical Staff relevant to a new procedure or technique, new equipment or instrument, or other training needs.

c. Temporary Clinical Privileges may be granted to a proctor from another organization for the purpose of supervising a Member of the Medical Staff as required by the Medical Executive Committee or as otherwise appropriate.

d. Preceptors and proctors referred to in b. and c. above are exempt from the application requirements described in Section V.D.2 below. Rather they are subject to the application requirements specified in the Medical Staff policy regarding visiting preceptors and proctors.

e. Temporary Clinical Privileges may be granted to a practitioner for no more than 120 days for the care of patients while a completed application is awaiting review and recommendation by the Medical Staff and approval by the Board of Trustees, provided the procedure described in Section V.D.2 has been followed, and that specific

temporary Clinical Privileges have been requested in writing by the provider, a current Medical Staff Member, or a member of the hospital administration team.

f. Locum Tenens

(i) Following the procedures in Section V.D.2., locum tenens privileges may be granted to a Practitioner who is a member in good standing of the clinical staff of another hospital, or can provide verifiable references from the last two hospitals where he or she has had privileges. The locum tenens privileges shall be limited to the provision of services on behalf of the Member for whom the locum tenens Practitioner is serving as locum tenens, including such patients assigned to him or her through the Emergency Department call schedule if applicable. At the discretion of the Medical Executive Committee, based upon the amount of time the locum tenens Practitioner works at Hospital, the locum tenens Practitioner may be required to seek permanent Staff privileges on the consulting or active Medical Staff in lieu of locum tenens privileges.

(ii) The locum tenens Practitioner is permitted to provide locum tenens coverage for members of the active Medical Staff without personally carrying the required level of malpractice insurance coverage. Instead each time he/she provides clinical coverage for a physician of the active Medical Staff, the covering physician may be insured under the malpractice insurance of the physician for whom he or she is covering. Such coverage will be verified by Medical Staff Services as appropriate.

(iii) The locum tenens Practitioner will be expected to complete all required medical record documentation prior to his or her departure from the Hospital. Failure to do so, after notice, may result in denial of a future request for privileges at the Hospital and being reported to the Wyoming Board of Medicine. That notwithstanding, ultimately it is the responsibility of the Member for whom the locum tenens Practitioner is covering to ensure that the required medical record documentation is completed within the specific time frames outlined in Medical Staff rules, regulations and policies.

V.D.2. <u>Grant of Temporary Clinical Privileges</u>

a. On receipt of a completed application and supporting documentation from a Practitioner authorized to practice in Wyoming, the Chief of Staff, or Medical Executive Committee designee, and Chief Executive Officer, or his or her designee, may grant temporary privileges to an applicant who appears to have qualifications, ability, and judgment,

consistent with Section II.B., but only after verification of the requirements in subsection II.B.1., as applicable to the Practitioner's licensure, scope of practice, and profession:

b. The applicant's file has been reviewed and approved by the Credentials Committee Chairman, Chief of Staff and Chief Executive Officer. If appropriate, peer review will be requested from an appropriate Practitioner (e.g., Service Chief, specialty representative to the Medical Executive Committee, or Physician of the same specialty which is not represented on the Medical Executive Committee) for review and recommendation to the Credentials Committee Chairman.

V.E. GENERAL CONDITIONS

V.E.1. If granted temporary privileges, the applicant shall act under the supervision of the appropriate Service Chief, and shall ensure the Service Chief is kept closely informed as to his or her activities within the Hospital.

V.E.2. Temporary privileges may be granted to a practitioner for no more than 120 days, and shall automatically terminate at the end of the designated period, unless earlier terminated by the Medical Executive Committee, or unless affirmatively renewed following the procedure as set forth in Section III.

V.E.3. Requirements for proctoring and monitoring shall be conducted in accordance with the medical staff QI program.

V.E.4. Temporary privileges may at any time be terminated by the Chief of Staff and the Chief Executive Officer subject to prompt review by the Medical Executive Committee. In such cases, the Chief of Staff shall assign a Staff Member to assume responsibility for the care of the patient(s) previously under the care of the Member holding temporary privileges. The wishes of the patient shall be considered in the choice of a replacement Staff Member.

V.E.5. A Practitioner shall not be entitled to the procedural rights afforded by Article VIII because a request for temporary privileges is denied or because all or any portion of temporary privileges are terminated or suspended unless the action or recommendation is reportable to the National Practitioner Data Bank pursuant to 42 U.S.C. § 11101 et seq. and 45 C.F.R. § 60 et seq., or their successors.

V.E.6. All persons requesting or receiving temporary privileges shall be bound by these Bylaws, the rules and regulations and the policies of the Medical Staff.

V.F. EMERGENCY PRIVILEGES

In the case of an emergency (defined as a condition in which the life or limb of a patient is in immediate danger and any delay in administering treatment would add to that danger), any person, whether a Medical Staff Member or not, to the degree permitted by his or her license and regardless of Staff status or Clinical Privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The person shall make every reasonable effort to communicate promptly with the Chief of Staff concerning the need for emergency care and assistance by Members of the Medical Staff with appropriate Clinical Privileges, and once the emergency has passed or assistance has been made available, shall defer to the Chief of Staff with respect to further care of the patient at the Hospital.

V.G. DISASTER PRIVILEGES

V.G.1. The Hospital, in conjunction with the Medical Staff, may grant Clinical Privileges, without following the process described in Section III., to licensed Physicians and/or other licensed independent practitioners only when the Hospital's emergency operations plan has been activated in response to a disaster, as defined herein, and the Hospital is unable to meet immediate patient care needs with Hospital Staff Members. During such disaster, every Staff Member may be deemed "temporarily privileged", as set out below, to provide any type of patient care necessary as a life-saving measure or to prevent serious harm, regardless of his or her current Clinical Privileges, so long as the care provided is within the scope of the individual's current license. Such temporary privileges ("disaster privileges") may likewise be granted by the Chief of Staff and the Chief Executive Officer or their designees upon to any licensed physician or other licensed independent practitioner (collectively, such Staff Members and licensed independent practitioners are referred to as "disaster practitioners") upon presentation of appropriate identification as outlined in the appropriate Medical Staff policy. The decision to grant disaster privileges will be made on a case-by-case basis, based upon then-present patient care needs and in the sole discretion of the Chief of Staff and/or the Chief Executive Officer, who will assign the disaster practitioner to provide services in a clinical area of the Hospital. The professional performance of each disaster practitioner will be overseen by a Medical Staff Member in charge of the specific assigned clinical areas.

V.G.2. Based on information regarding the disaster practitioner's professional practice, obtained from those Medical Staff Members overseeing the disaster practitioner's services, the Hospital will

decide within 72 hours whether to continue the disaster privileges initially assigned.

V.G.3. As soon as the disaster is under control and the Chief Executive Officer determines the Hospital's patient care needs can be met without Practitioners granted 'disaster privileges', Medical Staff Services will initiate the credentials verification and privileging process, as per policy, for those Practitioners who have been granted disaster privileges. The primary source verification of licensure, as described in the appropriate Medical Staff policies, shall be completed within 72 hours from the time Chief Executive Officer determines the Hospital's patient care needs can be met without Practitioners granted 'disaster privileges'. If this is not possible due to extraordinary circumstances, the process will be initiated as soon as possible and Medical Staff Services will ensure that it appropriately documents such circumstances, its credentialing efforts, and the disaster practitioner's demonstrated ability to continue to provide adequate care, treatment and services. Primary source verification is not required if the practitioner granted 'disaster privileges' has not provided care, treatment or services. For purposes of this section, a "disaster" is an emergency that, due to its complexity, scope or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety or security.

VI. NON-PHYSICIAN PROFESSIONAL STAFF AND ALLIED HEALTH PROFESSIONALS

VI.A. NON-PHYSICIAN PROFESSIONAL STAFF

The Non-Physician Professional Staff shall consist of dentists and/or oral surgeons, podiatrists, psychologists and chiropractors who meet the qualifications listed below. Non-Physician Professional Staff Members are permitted to participate in the provision of patient care services within the scope of their professional training. Such permissions shall be referred to as "practice prerogatives" and shall not be construed to afford Non-Physician Professional Staff the prerogatives of Medical Staff membership. Non-Physician Professional Staff Members are entitled to the hearing and appeal rights under these Bylaws. Non-Physician Professional Staff qualifications include the following:

a. Possess a current unrestricted license;

b. Document adequate experience, education, and training;

c. Demonstrate current professional competence;

d. Demonstrate good judgment;

e. Demonstrate adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff and Board of Trustees that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality care;

f. Are determined to:

(i) Adhere to the ethics of their respective professions;

(ii) Be able to work cooperatively, professionally and harmoniously with others, including other professional colleagues and Hospital personnel, so as not to adversely affect patient care;

(iii) Agree to function in an orderly manner;

(iv) Be willing to participate in and properly discharge those responsibilities determined by the Medical Staff and Board of Trustees; and

g. Comply with such requirements for professional liability insurance coverage as the Medical Executive Committee and the Board of Trustees shall specify.

VI.A.1. <u>Particular Qualifications</u>

a. Psychologists must hold a valid and unrestricted license to practice psychology issued by the Wyoming Board of Psychology.

b. Dentists and/or oral surgeons must hold a D.D.S. or equivalent degree issued by a dental school approved at the time of the issuance of such degree by the Wyoming Board of Dental Examiners and must also hold a valid and unsuspended certificate to practice dentistry issued by the Wyoming Board of Dental Examiner.

c. Podiatrists must hold a D.P.M. degree conferred by a school approved at the time of issuance of such degree by the Wyoming Board of Registration in Podiatry and must hold a valid and unsuspended certificate to practice podiatry issued by the Wyoming Board of Registration in Podiatry.

d. Chiropractors must hold a D.C., or equivalent degree issued by a chiropractic school approved at the time of the issuance of such degree by the Wyoming State Board of Chiropractic Examiners, and must hold a valid and unsuspended certificate to practice chiropractic issued by the Wyoming State Board of Chiropractic Examiners.

VI.A.2. <u>Prerogatives</u>

a. Non-Physician Professional Staff:

(i) May treat patients and utilize Hospital services, exercising independent judgment in the area of their expertise and

competence, and may exercise Clinical Privileges granted in the management of patients, in conjunction with a Medical Staff Member eligible to care for such patients;

(ii) May, but are not required to, attend educational programs and meetings of the Medical Staff or Medical Staff committees;

(iii) May serve as ex-officio members of one or more Medical Staff committees at the request of the Chief of Staff, Medical Executive Committee or committee chair;

b. Psychologists shall be members of the Behavioral Services Committee with full voting privileges and shall meet attendance requirements as outlined in Section XII.D. of these bylaws.

c. Non-Physician Professional Staff may be appointed by the Chief of Staff to other Medical Staff committees.

VI.A.3. <u>Limitations</u>

a. Non-Physician Professional Staff may not hold office in the Medical Staff organization or vote on matters before the Medical Staff with the exception of the Behavioral Services Committee and the Psychology Committee.

b. Non-Physician Professional Staff shall not hold admitting privileges at the Hospital except as outlined in Section VI.A.3.c.

c. A Non-Physician Professional Staff Member or applicant may petition the Medical Executive Committee on an individual basis for admitting privileges if he or she can provide adequate documentation of his or her training, experience, and competency to admit and care for patients independently throughout the hospital stay.

d. Non-Physician Professional Staff are not eligible to vote for Medical Staff officers or representatives to the Medical Executive Committee.

VI.A.4. <u>Responsibilities</u>

As a condition of applying for, or being granted, status as a Non-Physician Professional Staff Member and practice prerogatives, each applicant agrees that he or she shall:

a. Fulfill those responsibilities required by the Medical Staff Bylaws, rules and regulations, and service rules and regulations;

b. Retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Hospital for whom the Member is providing services;

c. Participate, as appropriate, in quality review, evaluation, and monitoring activities required of Members, in supervising initial appointees of the Member's same occupation or profession, and in discharging such other functions as may be required from time to time;

d. Serve on the committees to which the Member has been appointed by the Chief of Staff;

e. Attend and document attendance at educational programs in his or her field of practice; the Hospital accepts the continuing education requirements of the entity which licenses the Practitioner;

f. Comply with the terms and conditions of the granting of practice prerogatives and all policies, procedures and protocols that may be implemented by the service, Medical Staff or Hospital;

g. Maintain the confidentiality of all peer review related matters; and

h. Comply with such requirements for professional liability insurance coverage as the Medical Executive Committee and the Board of Trustees shall specify.

VI.B. ALLIED HEALTH PROFESSIONALS

AHPs may be granted permission to participate in the provision of certain patient care services. Such permissions shall be referred to as "practice prerogatives" and shall not be construed to afford AHPs the prerogatives of Medical Staff membership.

VI.B.1. Categories of AHPS Eligible for Practice Prerogatives

The Medical Executive Committee shall periodically review and identify the categories of AHPs eligible to apply for practice prerogatives in the Hospital. The Medical Executive Committee shall also identify the practice prerogatives and terms and conditions that may be granted to qualified AHPs in each category. The Hospital shall make available to the Medical Staff and any interested applicant a list of the AHP categories eligible for practice prerogatives. An AHP in a category not identified by the Medical Executive Committee as eligible for practice prerogatives may submit a request in writing to the Chief of Staff asking for consideration by the Medical Executive Committee. The Medical Executive Committee shall consider such request during its periodic review of the AHP categories. AHPs are entitled to the hearing and appeal rights under these Bylaws.

VI.B.2. Qualifications

To be eligible for practice prerogatives, an AHP must, as a minimum, meet the following requirements in addition to any requirements recommended by the Medical Executive Committee and the Board of Trustees:

a. Hold a current, unrestricted license, certificate or other appropriate legal credential in a category of AHPs that the Board of Trustees has identified as eligible for practice prerogatives. Should the AHP voluntarily relinquish or involuntarily have removed his or her unrestricted license, certification or other appropriate credential in his or her AHP field while on the Hospital's staff, the AHP will no longer meet the qualifications for membership and privileges on the Hospital's staff.

b. Document his or her background, relevant training, education, experience, demonstrated current competence, judgment, character, and physical and mental health status, with sufficient adequacy to demonstrate that patient care services will be provided by the AHP at the professional level of quality and efficiency established by the Medical Staff and the Hospital;

c. Document his or her strict adherence to the ethics of the Medical Staff and the AHP's respective profession; his or her ability and agreement to work cooperatively with others in the Hospital setting; and his or her willingness to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of the AHPs professional competence and credentials; and

d. Maintain professional liability insurance as required by these Bylaws and applicable Medical Staff policy.

VI.B.3. <u>Limitations</u>

a. AHPs may not hold office in the Medical Staff organization or vote on matters before the Medical Staff.

b. AHPs shall not hold admitting privileges at the Hospital. Notwithstanding the foregoing, a nurse practitioner or midwife may petition the Medical Executive Committee on an individual basis for admitting privileges, and must provide adequate documentation and verification from his or her supervising physician, of appropriate training, experience, and competency to admit and care for patients throughout the Hospital stay.

c. AHPs are not eligible to vote for Medical Staff officers or representatives to the Medical Executive Committee.

VI.B.4. <u>Responsibilities</u>

As a condition of applying for, or being granted, status as an AHP or practice prerogatives, each applicant agrees that he or she shall:

a. Fulfill those responsibilities required by the Medical Staff Bylaws, rules and regulations, and service rules and regulations;

b. Retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Hospital for whom the AHP is providing services;

c. Participate, as appropriate, in quality review, evaluation, and monitoring activities required of AHPs, in supervising initial appointees of the AHP's same occupation or profession, and in discharging such other functions as may be required from time to time;

d. Serve on Medical Staff, service and Hospital committees to which the AHP is requested by the Service Chief or Chief of Staff;

e. Attend the meetings of the relevant service, as permitted by the service rules and regulations;

f. Attend education programs in his or her field of practice, as may be required by the Hospital; the Hospital accepts the continuing education requirements of the entity which licenses or certifies the practitioner;

g. Comply with the terms and conditions of the granting of practice prerogatives and all policies, procedures and protocols that may be implemented from time to time by the service, Medical Staff or Hospital;

h. Maintain the confidentiality of all peer review related matters; and

i. Comply with such requirements for professional liability insurance coverage as the Medical Executive Committee and the Board of Trustees shall specify.

j. Identify and maintain a supervising physician who has and maintains active staff membership and appropriate Clinical Privileges.

VI.C. PROCEDURE FOR GRANTING PRACTICE PREROGATIVES

VI.C.1. Each Non-Physician Professional Staff Member and AHP must apply and qualify for practice prerogatives by submitting an application on the approved form, providing all necessary information, and agreeing to be bound by the applicable Bylaws, Rules and Regulations of the Medical Staff and Hospital policies. Applications for initial practice prerogatives, and renewal every three years thereafter, shall be submitted and processed in accordance with the procedures stated in Article VI of these Bylaws.

VI.C.2. Each AHP who is granted practice prerogatives shall be allowed to participate in the clinical service appropriate to the AHP's occupational or professional training and must identify and maintain a supervising physician on the active Medical Staff. Unless otherwise specified in these Bylaws or the Rules and Regulations, AHPs shall be subject to terms and conditions paralleling those in

Article V of these bylaws as they apply to the more limited practice of AHPs.

VI.D. TERMINATION OF PRACTICE PREROGATIVES

Either the Chief Executive Officer or the Chief of Staff may terminate an AHP's or Non-Physician Professional Staff Member's practice prerogatives, upon the occurrence of any of the following:

VI.D.1. Conduct by the Member which interferes with or is detrimental to the provision of quality patient care;

VI.D.2. Failure of the AHP to perform properly assigned duties;

VI.D.3. Suspension, revocation, expiration, voluntary or involuntary restriction, termination, or imposition of limitations by the applicable licensing or certifying agency of the Member's license, certificate or other legal credential which authorizes the Member to provide health care services;

VI.D.4. Termination of the Medical Staff membership of any supervising or collaborating Physician if applicable;

VI.D.5. Termination of the relationship between the AHP and any supervising or collaborating Physician if applicable;

VI.D.6. Failure of the Member to maintain required professional liability insurance;

VI.D.7. Failure of any supervising Physician to maintain active Medical Staff membership or Clinical Privileges in good standing if applicable; or

VI.D.8. Termination of the supervising Physician's contract or other relationship with the Hospital for any reason if applicable.

VI.E. LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws and by the Medical Staff or services' rules and regulations.

VII. ROUTINE MONITORING AND EDUCATION; INVESTIGATIONS; CORRECTIVE ACTION

VII.A. ROUTINE MONITORING AND EDUCATION

VII.A.1. Responsibility

It shall be the responsibility of the Chief of Staff and the Medical Executive Committee to design and implement an effective program (1) to monitor and assess the quality of professional practice in the Hospital and (2) to promote quality and efficiency of clinical and Hospital services by (a) providing education and counseling, (b) issuing letters of admonition, warning or censure, as necessary, and (c) requiring routine monitoring when deemed appropriate by the Medical Executive Committee.

VII.A.2. Procedure

a. Review and Studies. The Medical Executive Committee shall ensure that regular patient care reviews and studies of practice within the Hospital are conducted in conformity with the Hospital's general quality assessment and improvement plan and shall investigate complaints and practice-related incidents.

b. Informal Counseling. In order to assist Members in conforming their conduct or professional practice to the standards of the Medical Staff and the Hospital, the Chief of Staff or designee(s) may issue informal comments or suggestions, either orally or in writing. Such comments or suggestions shall be subject to confidentiality requirements and may be issued by the Chief of Staff or designee(s), with or without prior discussion with the recipient, and with or without consultation with the Medical Executive Committee. Such comments or suggestions shall not constitute a restriction of privileges, shall not be considered to be corrective action, as provided in Section VII.G., and shall not give rise to procedural rights under Article VIII of these Bylaws.

c. Letters of Admonition, Warning, or Censure and Routine Monitoring. Following discussion of identified concerns with any Member, the Medical Executive Committee may authorize the Chief of Staff to issue a letter of admonition, warning or censure, or to require such Member to be subject to routine monitoring for such time as may appear reasonable. The term "routine monitoring," as used in this Section VII.A.2., shall mean review of a Member's practice for which the Member's only obligation is to provide reasonable notice of admissions, procedures or other patient care activity. All Staff Members, regardless of status, shall be subject to potential routine monitoring. The discussions of such actions with individual Members shall be informal. Such action shall not constitute a restriction of privileges, shall not be considered to be corrective action, as provided in Section VII.G. of this Article, and shall not give rise to procedural rights under Article VIII.

d. Reporting to Medical Executive Committee. Actions taken pursuant to Section VII.A.2.b. need not be reported to the Medical Executive

Committee. Actions taken pursuant to Section VII.A.2.c. shall be reported to the Medical Executive Committee promptly after such actions are taken. Such actions taken pursuant to Subsection VII.A.2.c. shall be documented in the Member's credentials file.

VII.B. INVESTIGATIONS AND CORRECTIVE ACTION

For purposes of this Section VII.B, "Practitioner" shall mean a Practitioner that has been granted Clinical Privileges at the Hospital.

VII.B.1. Formal Investigations

a. Whenever, on the basis of information and belief, the Chief of Staff, a Service Chief, a majority of the Physicians on any Medical Staff committee, a Board officer, or the Chief Executive Officer has reasonable cause to question whether the professional conduct or clinical competence of a Practitioner meets the standards set out in the Bylaws, a written request for an investigation of the matter shall be made to the Chief of Staff on behalf of the MEC, making specific reference to the activity or conduct which gave rise to the request. The Chief of Staff may, upon receipt, conduct a preliminary investigation to determine the veracity and seriousness of the complaint allegations. The types of concerns for which formal investigations may be requested include, but are not limited to, the following:

   (i) The clinical competence of any Practitioner;

   (ii) The care or treatment of a patient or patients or the management of a case by any Practitioner;

   (iii) The known or reasonably suspected violation by any Practitioner of applicable ethical standards or the Bylaws, policies, or Rules and Regulations of the Medical Staff, the Hospital or the Board;

   (iv) Behavior or conduct on the part of any Practitioner that is considered disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the Practitioner to work harmoniously with others, including but not limited to employees and Medical Staff; or

   (v) The known or suspected violation of any federal, state, or local law by any Practitioner.

b. When a written investigative request has been made to the MEC, the MEC may:

   (i) Approve an investigation, if the information provided reasonably supports doing so; or

(ii) Decline to approve the investigation, if the information provided does not reasonably support approving the investigation.

c. Conduct of investigation.

(i) The MEC shall delegate the investigation to an "Investigator", which shall be appointed by the MEC and consist of:

(A) An investigational committee of Medical Staff Members, appointed by the MEC; or

(B) An individual Medical Staff Member; or

(C) A person, or committee of persons, retained by the Medical Staff, who by experience or qualifications are qualified to conduct such investigations.

(ii) The Investigator shall not include any person in direct economic competition with the Practitioner, a business associate or relative of the Practitioner.

(iii) The Investigator shall use the Investigator's best efforts to maintain the anonymity of persons requesting to remain anonymous (e.g., a witness to an event or the complaining individual), although anonymity cannot be guaranteed. Persons presenting information in good faith to the Investigator shall have all the protections afforded by federal (including 42 U.S.C. § 11111) and Wyoming law (including W.S. § 35-17-105). No Practitioner shall attempt to retaliate against or intimidate any complainant or person providing information to the Investigator for making a complaint or providing such information.

(iv) The Chief Executive Officer may, and shall at the MEC's or Investigator's request, retain legal counsel to represent the Investigator to ensure compliance with Medical Staff Bylaw provisions and legal requirements. The Investigator shall have available to it the full resources of the Medical Staff and the Hospital to aid in its work, as well as the authority to use outside consultants as reasonably required.

d. The investigation shall proceed as follows:

(i) The Chief of Staff shall promptly notify the Practitioner and the CEO of any approved investigation, and the identity of the appointed Investigator.

(ii) The Investigator shall investigate the allegations in the complaint, and any defenses asserted by the Practitioner, as appropriate under the circumstances, including but not limited to interviewing the complainant and witnesses and reviewing medical records and documents relevant to the allegations. The

Investigator may review the Practitioner's Medical Staff credentials records to the extent relevant to the allegations.

(iii) Preliminary interview. The Practitioner shall be given an opportunity for a preliminary interview with the Investigator. At the preliminary interview, the Practitioner shall be informed of the general nature of the investigation and the evidence supporting the investigation, and shall be invited to discuss, explain, or refute the information provided. The Investigator is not required to disclose the name of any person or witness that has requested anonymity, unless the Practitioner could not reasonably respond to the complaint or provide sufficient information without it. This preliminary interview shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings, including the right to be represented by counsel, shall apply. The Practitioner shall have the opportunity to submit a written statement to the Investigator following the interview, and a summary of the interview shall be made by the Investigator and included, along with the Practitioner's written statement (if any), with the report to the MEC.

(iv) The Investigator shall complete its investigation and recommendation within a reasonable time as determined by the MEC. Upon completion, the Investigator shall prepare a written report, which shall be delivered to the MEC. The written report shall include:

(A) The specific complaint against the Practitioner;

(B) A specific statement of the violations of potential violations of Medical Staff Bylaws, Rules and Regulations, and/or Policies provisions on which the investigation was based;

(C) A summary of the evidence (including exculpatory evidence) received by the Investigator;

(D) The statement of the Practitioner, should the Practitioner choose to submit one in writing prior to the meeting of the Medical Executive Committee to review the Investigator's report;

(E) A listing of the Medical Staff Bylaws, Rules and Regulations, and/or Policies, or Hospital Bylaws or Policies or laws that were not met and a description of how each was not met;

(F) A recommended course of action; and

(G) A summary of the chronology of the peer review investigation from the initial complaint through the conclusion of the investigation.

e. The MEC shall provide the Practitioner a copy of the Investigator's report, and shall offer the Practitioner an opportunity to meet with the MEC within a reasonable time to discuss the Investigator's findings. The meeting shall not constitute a hearing, and none of the procedural rules set out in these Bylaws for hearings shall apply.

f. Upon receipt of the Investigator's report and after having met with the Practitioner (if requested), the MEC shall meet as soon as reasonably possible to decide what action to take, if any, on the basis of the report and the information in the Practitioner's credentials file. The MEC may:

(i) Take no action if the evidence does not reasonably support taking any;

(ii) Take action which will not affect the Practitioner's Clinical Privileges, or duties, rights and/or obligations of Medical Staff membership, such as issuing a written warning or letter of reprimand or imposing a term of probation, which will not entitle the Practitioner to a hearing pursuant the Bylaws; or

(iii) Make a recommendation to the Board to restrict, suspend, reduce or terminate the Practitioner's Clinical Privileges and/or duties, rights and/or obligations of Medical Staff membership, or impose a mandatory consultation requirement. Any such recommendation will entitle the Practitioner to a hearing pursuant to the Bylaws.

g. The MEC shall prepare a report documenting its decision, and its recommendation for action if a recommendation is made. The report shall include:

(i) The Investigator's report;

(ii) The statement made, in writing, by the Practitioner which was submitted with the Investigator's report;

(iii) Any additional facts or information considered by the Medical Executive Committee; and

(iv) The decision and recommendation of the Medical Executive Committee which shall include:

(A) A statement of the oral and documentary evidence considered by the Medical Executive Committee which formed a basis for the recommendations;

(B) Findings of fact which are the basis of each recommendation of the Medical Executive Committee;

(C) A listing of the Hospital Bylaws, Rules and Regulations, Policies, or the laws or regulations that were found not to have been met and a description of how each was not met; and

(D) Conclusions and, if made, recommendations of the Medical Executive Committee.

h. The MEC shall forward its report and recommendation(s) (if any) to the Chief Executive Officer.

(i) When a recommendation is made which, according to Section VII.G.1. entitles the Practitioner to a hearing prior to a final decision of the Board, the Practitioner shall promptly be given notice by the Chief of Staff, in writing, certified mail, return receipt requested and by first class mail. This notice shall contain:

(A) A copy of the MEC's report;

(B) Notice that the Practitioner has the right to request a hearing on the recommendation within a time period of up to thirty (30) days of the date of the certified mailing of the notice; and

(C) A copy of Articles VII and VIII, outlining the Practitioner's rights to a hearing.

(ii) The Practitioner shall be given a specified time period of up to thirty (30) days following the date of the certified mailing of such notice within which to request a hearing pursuant to these Bylaws.

(A) The Practitioner's hearing request shall be made by written notice to the Chief of Staff. The Chief of Staff shall provide the Chief Executive Officer a copy of the request, and the proceedings shall continue in accordance with Article VIII.

(B) If the Practitioner does not request a hearing within the time and in the manner herein above set forth, that Practitioner shall be deemed to have waived the right to such hearing and to have accepted the MEC's decision and recommendation and all actions leading up to and including the decision and recommendation.

(C) In the event that the Practitioner expressly waives or is deemed to have waived the right to a hearing, the MEC's recommendation and report shall be forwarded immediately to the Board. The Board shall accept the MEC's recommendation if supported by substantial

evidence, and is reasonable, and not arbitrary, capricious or contrary to law. Such action shall become effective immediately upon final Board approval.

i. The MEC will make its decision to take no action, take action not entitling the Practitioner to a hearing, or make a recommendation for action entitling the Practitioner to a hearing, within a reasonable time as determined by the MEC.

VII.C. PRECAUTIONARY SUSPENSION OF MEMBERSHIP AND/OR CLINICAL PRIVILEGES

The Chief of Staff (or his or her designee) and the Chief Executive Officer (or his or her designee), shall impose a precautionary suspension of any portion or all of the duties, rights and/or obligations of any Medical Staff Member, or Clinical Privileges of any Practitioner or Non-Physician Professional Staff, whenever such action is reasonably necessary to avoid the substantial likelihood of significant and imminent impairment to the life, health, or safety of any patient or other person, including any Medical Staff Member or Practitioner, visitor or Hospital staff. Such precautionary suspension shall be deemed an interim precautionary step in the professional review or quality management activity related to the ultimate professional review action that will be taken with respect to the Practitioner, but is not a final professional review action in and of itself. The scope of any such precautionary suspension, both time and restrictions, should not be more than reasonably necessary to avoid the risk identified above.

VII.C.1. Effect of Precautionary Suspension

a. A precautionary suspension shall become effective immediately upon imposition; shall be reported immediately, in writing, to the Chief Executive Officer, the Chief of Staff, and the MEC; and shall remain in effect until and unless modified by the MEC. Any precautionary suspension lasting more than fourteen (14) days shall entitle the Practitioner to the hearing and appeal rights described in these Bylaws regarding whether the precautionary suspension was appropriate.

b. The Chief of Staff and the Chief Executive Officer, or designees shall notify the Practitioner verbally of his or her precautionary suspension, and the reasons why the suspension was instituted. This verbal notification shall be followed by written notice of the precautionary suspension from the Chief of Staff, or the Chief Executive Officer, or designee, as applicable.

VII.C.2. MEC Review of Precautionary Suspension

a. Within five (5) business days after the precautionary suspension is imposed, the MEC shall review the information and facts that were the reasons for the precautionary suspension and shall recommend that the precautionary suspension be confirmed, modified, or ended.

b. The MEC shall issue its recommendation in a written report.

c. The MEC shall forward its recommendation and report to the Chief Executive Officer.

d. When a recommendation is made which entitles the Practitioner to a hearing under the Bylaws prior to a final decision of the Board, the Practitioner shall be provided notice in accordance with Section VII.B.1.h., and the procedures outlined therein and in the Article VIII shall be followed.

VII.C.3. MEC Investigation

Upon the conclusion of its review of the precautionary suspension, the MEC may initiate a formal investigation of the Practitioner as described in Section VII.B.1.

VII.C.4. Automatic Suspension

A Practitioner may have some or all of his or her Clinical Privileges, and any attendant rights and benefits of those Clinical Privileges, suspended, restricted or revoked, as applicable, under the following circumstances. In that case, the Chief of Staff and/or Chief Executive Officer of the Hospital shall immediately notify the Practitioner and Medical Executive Committee of the suspension, restriction and/or revocation. If such notification is not immediately made in writing, it shall be made in writing as soon as reasonably practicable.

VII.C.5. Delinquent Medical Records

a. Members are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee and defined in these Bylaws and/or rules and regulations of the Medical Staff. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, may be imposed by the Chief of Staff, or his or her designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section VII.D.1., "related privileges" means scheduling surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff or his or her designee.

b. If a Member remains suspended pursuant to this Section VII.D.1. for longer than thirty (30) days, the Chief of Staff may notify the Member in writing that his or her membership and Clinical Privileges will terminate unless he or she completes all outstanding medical records within fifteen (15) days following receipt of that notice. If the Member fails to complete all outstanding medical records within fifteen (15) days following receipt of this notice, the Member shall be deemed to have relinquished his or her membership and Clinical Privileges voluntarily.

VII.C.6. License, DEA Registration

a. A Practitioner's Clinical Privileges and/or Medical Staff membership shall be automatically revoked, suspended or restricted, as applicable as the result of action and to the same extent the Practitioner's license to practice medicine, DEA registration or Wyoming State Board of Pharmacy controlled substance registration is revoked, suspended or restricted by the Wyoming Board of Medicine, Drug Enforcement Administration, or Wyoming State Board of Pharmacy as applicable.

b. The Clinical Privileges of a Non-Physician Professional Staff Member shall be automatically revoked, restricted or suspended in the event of action, and to the same extent, as any agency responsible for the licensure or certification of any Non-Physician Professional Staff Member, revokes, restricts or suspends the licensure or certification of that Non-Physician Professional Staff Member in Wyoming.

c. In the event the Wyoming Board of Medicine or licensing agency reinstates the Practitioner's license, the Medical Staff may initiate an investigation pursuant to these Bylaws before reinstating Clinical Privileges and/or Medical Staff membership. If the MEC makes a recommendation to continue the suspension or restriction of, or not to reinstate, the Practitioner's Clinical Privileges and/or Medical Staff membership, the Practitioner shall be provided with notice as described in Section VII.B.1.h. and entitled to a hearing pursuant to these Bylaws.

VII.C.7. Failure to Appear at Medical Record Presentation

A Practitioner whose patient's medical record is to be presented for Medical Staff quality improvement review or peer review, who has been duly notified in advance of such presentation, and whose absence from such Medical Staff meetings had not been formally approved, may have all or part of his or her Clinical Privileges and/or Medical Staff membership, automatically suspended for a period of thirty (30) days or less in the Chief of Staff's discretion for failure to appear at the meeting.

VII.C.8. Failure to Reply

A Practitioner who has been requested to reply, in writing, by any committee after notification by certified mail and who does not reply within two (2) weeks after such request may have his or her Clinical Privileges and/or Medical Staff membership automatically suspended.

VII.C.9. Failure to Maintain Professional Liability Insurance

Failure to maintain professional liability insurance in amounts determined by the Medical Staff and Board shall be grounds for automatic suspension of a Practitioner's Clinical Privileges. If within thirty (30) days after written warnings of the delinquency the Practitioner does not provide evidence of required professional liability insurance, his or her Medical Staff Membership and/or Clinical Privilege shall be deemed to be a voluntarily relinquished.

VII.C.10. Termination of Exclusive Contract

A Member who has entered into a contract to provide services to the Hospital on an exclusive basis either as an individual or through a group practice shall be automatically terminated from the Medical Staff upon termination of an individual or group contract or upon leaving a group that has an exclusive contract with the Hospital. Notwithstanding the foregoing, the Board of Trustees may permit individuals whose exclusive group or individual contract has terminated or who have left the group that has an exclusive contract to remain on the Staff upon such occurrence if the individual agrees not to have privileges in the specialty subject to the exclusive arrangement in the specialty subject to the exclusion. Notwithstanding the foregoing, an individual:

a. Who provides services to the Hospital through an exclusive group or individual contract immediately following a terminated exclusive contract shall not be automatically terminated from the Medical Staff; or

b. Who has privileges to provide services which are not the subject of the exclusive contract shall not be automatically terminated as long as he or she forfeits his or her privileges which are the subject of the exclusive contract.

VII.C.11. Termination or Revocation of Medicare or Medicaid Status

A Member who has been suspended, terminated or excluded from Medicare or Medicaid shall likewise be immediately automatically suspended or terminated from the Medical Staff.

VII.C.12. <u>Duty of Chief of Staff</u>

It shall be the duty of the Chief of Staff to determine which aspects of a Practitioner's Clinical Privileges and/or Medical Staff membership to suspend, and for how long, under Subsections VII.D.3 (Failure to Appear at Medical Record Presentation) and VII.D.4 (Failure to Reply), and to cooperate with the Chief Executive Officer, and the Board in enforcing all suspensions, revocations and restrictions. All Practitioners and Non-Physician Professional Staff shall cooperate with the Chief of Staff, the Credentials Committee, and the Chief Executive Officer, in enforcing all suspensions, revocations and restrictions.

VII.C.13. <u>Procedural Rights</u>

a. Any suspension or restriction of a Practitioner's Clinical Privileges and/or Medical Staff membership lasting fourteen (14) days or more shall entitle the Practitioner to notice of his or her right to a hearing, under Section VII.B.1.h, and the procedural rights set forth in Article VIII. A hearing, if requested, shall be limited to the question of whether the grounds for automatic suspension have occurred.

b. It shall be the duty of all Members of the Medical Staff and Non-Physician Professional Staff to cooperate with the Chief of the Medical Staff, the Credentials Committee, and the Chief Executive Officer in enforcing all suspensions.

VII.D. CARE OF SUSPENDED PRACTITIONER'S PATIENTS

Immediately upon the imposition of a precautionary or automatic suspension, the appropriate Service Chief or, if unavailable, the Chief of Staff, shall assign any Hospital inpatients of the Practitioner to the care of another Practitioner(s) with appropriate Clinical Privileges. This assignment shall be effective until such time as the patients are discharged or the relevant aspects of the precautionary or automatic suspension are ended. The wishes of the patient shall be considered in the selection of the assigned Practitioner.

VII.E. CONFIDENTIALITY OF INFORMATION

Any and all requests, investigations, actions, decisions not to act, and/or settlements pursuant to this Section are deemed to be in furtherance of the purposes and requirements of the Health Care Quality Improvement Act of 1986 (42 U.S.C. §§ 11101 et. seq.) and Wyoming law (W.S. §§ 35-2-910 and 35-17-101 to 106). All such activity, and the materials related thereto, are considered confidential and cannot be disclosed to persons outside the Hospital or its Medical Staff pursuant to, among others, the Health Care Quality Improvement Act of 1986 and Wyoming law (W.S. §§ 16-4-203, 35-2-609, 35-2-910, and 35-17-101 to 106), unless otherwise required or permitted by law.

VII.F. CORRECTIVE ACTION

VII.F.1. A Practitioner is entitled to request a hearing only for those actions constituting "professional review actions", defined as actions or recommendations which are based on the clinical competence or professional conduct of an individual Practitioner and when the Practitioner's Clinical Privileges or Medical Staff appointment are adversely affected, within the meaning of the federal Health Care Quality Improvement Act, and otherwise as required under Wyoming law. Therefore, a hearing is triggered only by the following actions, if based on the professional conduct or clinical competence of the affected Practitioner:

a. Denial of initial Medical Staff appointment;

b. Denial of requested advancement in a Medical Staff category;

c. Denial of Medical Staff reappointment;

d. Restriction or suspension of the rights and/or benefits, or revocation, of Medical Staff appointment for a period lasting more than fourteen (14) days;

e. Denial of requested Clinical Privileges, whether initially requested or request for new Clinical Privileges; and

f. Involuntary suspension or restriction of Clinical Privileges for a period lasting more than fourteen (14) days.

VII.F.2. Actions by the Medical Staff and/or Hospital that do not fall into the categories outlined above shall not entitle the Practitioner to a hearing as described in these Bylaws. Such actions include, but are not limited to oral or written reprimands and warnings.

VII.F.3. A Practitioner may make a written request for a hearing in accordance with Section VII.B.1.h. when any of the actions described above in Section VII.G.1. is recommended by the MEC to the Board, or taken by the Board without a recommendation by the MEC. Whenever a Practitioner makes a proper request under the circumstances described in Section VII.G.1.A. the hearing shall be conducted and thereafter proceed as described in these Bylaws.

VII.G. REPORTING ACTION TAKEN

The following shall be reported to the Wyoming Board of Medicine and the National Practitioner Data Bank. (See 42 U.S.C. § 11133 and W.S. § 33-26-409):

VII.G.1. A professional review action that adversely affects the Medical Staff membership and/or Clinical Privileges of a Wyoming-licensed Physician for a period exceeding thirty (30) days;

VII.G.2. The acceptance of a surrender of a Wyoming-licensed Physician's Clinical Privileges:

a. While the Physician is under investigation by the Hospital for possible incompetence or improper professional conduct; or

b. In return for not conducting an investigation as specified in this subparagraph.

VII.G.3. Any action taken against a Physician for which the Wyoming Board of Medicine may take disciplinary action (see W.S. § 33-26-402), or on the basis that the Physician is or was "impaired", within the meaning of the Wyoming Medical Practice Act, and any action described in subsection (a) or (b), above, shall be reported to the Wyoming Board of Medicine

VII.G.4. For the purposes of reportability under this Section VII.H, an adverse action, including precautionary or automatic suspension as described above, shall not be a "professional review action" until all procedures and appeals in the Medical Staff Bylaws have been completed or waived and there has been a final action by the Board.

VIII. CONTESTED CASE AND APPELLATE REVIEW PROCEDURES

VIII.A. RIGHT TO HEARING AND APPELLATE REVIEW PROCEDURES

VIII.A.1. Any proceeding under these Bylaws shall be a contested case governed by the Wyoming Administrative Procedure Act and these rules.

VIII.A.2. An affected Practitioner shall have the right to a hearing when the Medical Staff takes any of those action described in Section VII.G.1. of the Medical Staff Bylaws, and no others.

VIII.A.3. An affected Practitioner may make a written request for a hearing, in accordance with Section VII.B.1.h. of the Medical Staff Bylaws, when action is taken by the Medical Staff which entitles the affected Practitioner to a hearing.

VIII.B. HEARING PANEL, HEARING OFFICER, OR ARBITRATOR

VIII.B.1. When a hearing is requested, the Chief of Staff, in consultation with the Medical Executive Committee, shall appoint a Hearing Panel comprised of a minimum of three (3) individuals who shall be:

a. Members of the Medical Staff who are in good standing, have not participated in the investigation or previous consideration of the matter, and who are not in direct or indirect competition with the affected Practitioner, as described in Section VIII.B.3, below;

b. Physicians not connected with the Hospital nor in direct or indirect competition with the affected practitioner, as described in Section VIII.B.3. below; or

c. A combination of a and b of this subsection.

VIII.B.2. Utilization of persons outside the Hospital shall not constitute a waiver of the confidentiality of the proceedings or of information considered and developed during the proceedings. The selection of persons not connected with the Hospital shall be for the purpose of obtaining an unbiased Hearing Panel to render an impartial decision and/or to obtain expertise in a particular specialty or subject. All persons selected to comprise the Hearing Panel shall execute a confidentiality agreement which is in substantial compliance with W.S. §35-2-910 and W.S. §35-17-101 and the 42 U.S.C. § 11111.

VIII.B.3. The Hearing Panel shall not include any individual who is in direct or indirect economic competition with the affected Practitioner, any individual who is professionally associated with the affected Practitioner, or any person who is related to the affected Practitioner. Mere awareness of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

VIII.B.4. In addition to the appointment of the Hearing Panel, the Chief of Staff shall also appoint a Hearing Officer, who shall preside over the hearing and any pre-hearing matters. The Hearing Officer shall also be available to advise the Hearing Panel on any legal issues, and shall be allowed to participate as an ex-officio member of the Hearing Panel, but shall not be allowed to vote. The Hearing Officer shall be a member of the Wyoming State Bar in good standing and should be familiar with healthcare law, or have substantial trial or judicial experience. The Hearing Officer shall have all the powers specified in the Wyoming Administrative Procedure Act (W.S. §16-3-101, et seq.) and shall:

a. Administer oaths and affirmations;

b. Issue subpoenas;

c. Rule upon offers of proof and receive relevant evidence;

d. Take or cause to be taken depositions in accordance with the provisions of the Wyoming Administrative Procedure Act;

e. Regulate the course of the hearing;

f. Hold conferences for the settlement or simplification of issues;

g. Dispose of procedural requests or similar matters;

h. Receive arguments by the parties or their representatives on issues related to the introduction of evidence outside the presence of the Hearing Panel;

i. Have the authority and discretion, in accordance with this Article, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;

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

k. Maintain decorum throughout the hearing;

l. Act in such a way that all information reasonably relevant to the continued appointment or Clinical Privileges of the affected Practitioner is considered by the Hearing Panel in formulating its recommendations;

m. Draft the findings of fact and conclusions of law at the direction of the Hearing Panel;

n. Advise the Hearing Panel as to the law; and

o. Issue protective orders.

VIII.B.5. Arbitrator

a. As an alternative to a Hearing Panel, a hearing may be held before an Arbitrator(s) mutually acceptable to the affected Practitioner and the Medical Executive Committee. The Arbitrator(s) may be selected from the AHLA (American Health Lawyers Association), or its successor or its alternative dispute resolution service.

b. The Arbitrator(s) may not be any individual who is in direct or indirect economic competition with the affected Practitioner, any individual who is professionally associated with the affected Practitioner, or any person who is related to the affected Practitioner.

c. In the event an Arbitrator(s) is/are appointed instead of a Hearing Panel, all references in this Article to the Hearing Panel shall be deemed to refer instead to the Arbitrator, unless the context would clearly indicate otherwise.

VIII.B.6. Unbiased Panel

Unless required for the disposition of ex parte matters authorized by law, or for precautionary or automatic suspensions as provided by the Medical Staff Bylaws, no Member of the Medical Staff or other person shall serve on the Hearing Panel, or as a Hearing Officer or Arbitrator, if that person was engaged in the investigation, preparation, presentation or prosecution of the contested case.

VIII.C. NOTICE OF HEARING AND STATEMENT OF REASONS

VIII.C.1. The Chief of Staff shall schedule the hearing and shall notify the affected Practitioner, by certified mail, return receipt requested of the following:

a. The time, place, date and nature of the hearing;

b. The legal authority and jurisdiction under which the hearing is to be held;

c. The names of the Hearing Panel members, Hearing Officer, or Arbitrator(s) if known;

d. The particular sections of the statutes, Hospital rules, bylaws or policies involved;

e. A short statement of the matters asserted including the report of the Medical Executive Committee; and

f. A summary of the procedural rights afforded under this Article and a request that the affected Practitioner provide additional evidence or information relevant to the subject of the proposed action.

VIII.C.2. The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

VIII.D. PRE-HEARING DISCOVERY

VIII.D.1. Discovery shall be available to the parties as allowed by the Wyoming Administrative Procedure Act, W.S. §16-3-107. The information used and developed by the Medical Executive Committee in the investigation of the affected Practitioner, subject to all applicable legal privileges and confidentiality requirements,

and the recommendation of the professional review action will be made available to the affected Practitioner upon the receipt of a written request for the information and subject to the following stipulations in order to facilitate the confidentiality of the patient care and peer review information:

a. This information shall be only made available to the affected Practitioner subject to a stipulation, signed by the affected Practitioner and the Chief Executive Officer that such documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing process.

b. The affected Practitioner may:

(i) Review the medical records of the patients whose treatment is the subject of the contested case. These records shall only be reviewed by the affected Practitioner while he or she is in the presence of a Hospital employee or a Medical Staff Member authorized to supervise the review of the patient records;

(ii) Obtain copies of the medical records of the patients whose treatment is the subject of the contested case. The affected Practitioner shall be responsible for the costs of copying the records requested;

(iii) Obtain copies of reports of experts relied upon by the Investigating Committee and/or the Medical Executive Committee;

(iv) Obtain copies of relevant committee minutes (which may be redacted, within the discretion of the committee chair to protect the confidentiality of the thought processes of the committee). This provision does not constitute a waiver of any applicable legal privilege or confidentiality requirement, including the attorney-client privilege, or the quality management, medical staff and peer review protection laws); and

(v) Obtain copies of any other documents relied upon by the Investigating Committee or the Medical Executive Committee. (This provision does not constitute a waiver of any applicable legal privilege or confidentiality requirement, including the attorney-client privilege, or quality management, medical staff and peer review protection laws.)

VIII.D.2. The Hearing Officer shall issue a pre-hearing order which sets discovery deadlines, time line for the hearing, a pre-hearing motions deadline, deadlines for objections to evidence and such other hearings and deadlines as are necessary for the orderly administration of the hearing.

VIII.D.3. Upon the request of the Medical Executive Committee and/or its counsel, the affected Practitioner shall make available copies of records and documentation that he or she intends to use in support of his or her position. The Hospital shall be responsible for the costs of copying any documents or information requested. Such documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing process.

VIII.D.4. Prior to the hearing, on a date set by the Hearing Officer or agreed upon by counsel for both sides, each party shall provide the other party with a list of proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the hearing.

VIII.E. FAILURE TO APPEAR

Failure of the affected Practitioner to appear at his or her requested hearing without good cause shall constitute a voluntary waiver of the right to a hearing and the Hearing Panel shall adopt the recommendation of the Medical Executive Committee. The Hearing Panel shall prepare a report explaining that the affected Practitioner, having received proper notice of the hearing, failed to appear at the hearing, and that the Hearing Panel adopts the recommendation of the Medical Executive Committee in accordance with Contested/Appellate Review. The report of the Hearing Panel shall be delivered to the Chief of Staff and the Chief Executive Officer. The Chief Executive Officer shall forward the Hearing Panel report, the recommendation, and all supporting documentation to the Governing Board as provided in Section VIII.N.

VIII.F. RECORD OF HEARING

VIII.F.1. The Hearing Officer shall maintain a record of the hearing by having a certified court reporter present to make a record of the hearing or by electronic recording of the hearing. The cost of such record shall be borne by the Hospital, but copies of the transcript shall be provided to the affected Practitioner at that individual’s expense.

VIII.F.2. All oral testimony entered into the record shall be given under oath or affirmation. The oath or affirmation shall be administered by any person entitled to notarize documents in the State of Wyoming.

VIII.F.3. The record of the hearing shall include the following:

a. The report of the Investigator (if any), or Credentials Committee (with respect to hearings on denial of requested medical Staff appointment or Clinical Privileges);

b. The report and recommendation of the Medical Executive Committee;

c. Copies of all formal or informal notices, pleadings, motions and intermediate recommendations;

d. Any additional facts or information considered by the Hearing Panel;

e. Evidence received or considered, including a transcript of the hearing;

f. Questions and offers of proof, objections and rulings thereon;

g. Any proposed findings of the Hearing Panel and exceptions thereto; and

h. The decision and recommendation of the Hearing Panel which shall include:

   (i) All relevant facts that are important to understanding the basis of the recommendation(s);

   (ii) Findings of fact which are the basis of each recommendation of the Hearing Panel; and

   (iii) Conclusions of law listing the Bylaws, Rules and Regulations, or policies of the Medical Staff and/or Hospital, or laws or regulations, that were violated, if any, and a description of how each was violated.

VIII.G. RIGHTS OF BOTH SIDES

VIII.G.1. At the hearing, both sides shall have the following rights, subject to reasonable limits determined by the Hearing Officer:

a. To evaluate the Hearing Panel for bias (voir dire);

b. To call and examine witnesses;

c. To compel the appearance of witnesses within jurisdictional limits for the purpose of taking evidence or requiring the production of books, papers, documents, or tangible things by requesting that the Hospital, through the Hearing Officer, subpoena witnesses;

d. To introduce exhibits;

e. To cross-examine witnesses on any matter relevant to the issues and to rebut any evidence;

f. To be represented by legal counsel (at each party's own expense), licensed in the State of Wyoming, who may call, examine, and cross-examine witnesses and present the case;

g. To present oral arguments on all issues involved;

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

i. To submit proposed Findings of Fact and Conclusions of Law.

VIII.G.2. Any affected Practitioner who requests a hearing who does not testify on their own behalf may be called by the Medical Executive Committee or Hearing Panel, and examined as if under cross-examination, however, such person may exercise his or her privilege against self-incrimination found in the Fifth Amendment to the Constitution of the United States.

VIII.H. ADMISSIBILITY OF EVIDENCE

VIII.H.1. The hearing shall be conducted in accordance with the Wyoming Administrative Procedure Act;

VIII.H.2. All testimony at the hearing shall be received under oath;

VIII.H.3. Hearsay evidence shall not be excluded merely because it constitutes hearsay; but shall be given appropriate weight in considering the facts;

VIII.H.4. Any relevant evidence shall be admitted if it is the sort of evidence on which reasonably prudent persons are accustomed to relying in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Irrelevant, immaterial or unduly repetitious evidence shall be excluded;

VIII.H.5. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Panel may request such a memorandum to be filed, following the close of the hearing; and

VIII.H.6. The Hearing Panel may interrogate witnesses, call additional witnesses or request documentary evidence which it deems appropriate.

VIII.I. OFFICIAL NOTICE

VIII.I.1. The Hearing Panel shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration in accordance with the Wyoming Administrative Procedure Act §16-3-108(d). Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing.

VIII.I.2. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

VIII.J. POSTPONEMENTS AND EXTENSIONS

On a showing of good cause, postponements and extensions of time beyond any time limit set forth in this Article may be requested by anyone, but shall be permitted only by the Hearing Officer.

VIII.K. PRESENTATION OF CASE

VIII.K.1. The Medical Executive Committee or its representative shall first present evidence in support of its recommendation. Thereafter, the affected Practitioner shall have the opportunity to present witnesses and evidence in support of his or her position. The Medical Executive Committee shall then have the opportunity to present rebuttal evidence.

VIII.K.2. The Medical Executive Committee shall have the burden of proof to introduce admissible evidence which supports its recommendation by clear and convincing evidence.

VIII.L. ADJOURNMENT AND CONCLUSION

The Hearing Panel may adjourn the hearing and reconvene the same at its discretion for the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

VIII.M. DECISION OF THE HEARING PANEL

VIII.M.1. The Hearing Panel shall issue its decision in writing to the Chief of Staff and the Chief Executive Officer within a reasonable time after the final adjournment of the hearing.

VIII.M.2. The Hearing Panel shall conduct its deliberations in private and its deliberations shall be confidential and privileged. The Hearing Officer may be present during deliberations to give advice on the law and to assist in the preparation of the findings of fact and conclusions of law. The Hearing Officer shall have no vote in the final determination.

VIII.M.3. The decision of the Hearing Panel shall be based on the evidence presented at the hearing. The evidence may consist of the following:

a. Oral testimony of witnesses;

b. Memoranda of points and authorities presented in connection with the hearing;

c. Any information regarding the individual who requested the hearing so long as that information has been admitted into evidence at the hearing and the affected Practitioner had the opportunity to comment on, rebut the evidence, or to cross-examine the witness presenting that evidence;

d. Any and all applications, references, and accompanying documents admitted into evidence at the hearing;

e. Other documented evidence, including medical records and the reports of Medical Staff committees admitted into evidence at the hearing; and

f. Any other evidence that has been admitted at the hearing.

VIII.M.4. The written decision (the Report) of the majority of the Hearing Panel shall accept or reject the MEC's recommendation and shall include:

a. A summary of the chronology of the peer review proceedings, from the initial complaint through the conclusion of the hearing;

b. Identification of the representatives of the participants;

c. A statement of the issues in the case;

d. Findings of Fact and Conclusions of Law and a listing of the applicable Bylaws, Rules and Regulations, or policies of the Medical Staff or Hospital, and/or laws and regulations, that were not met by the affected Practitioner (if any) and a description of how each was not met.

e. The findings and decision of the Hearing Panel along with the recommendations of the Hearing Panel.

f. In the event that one or more members of the Hearing Panel do not agree with the findings or recommendations of the majority, these persons may offer a written dissent that shall be included with the written decision of the Hearing Panel. Any written dissent shall include:

   (i) A description of the facts and/or recommendations in dispute;

   (ii) A statement describing the basis for the dispute of the facts and/or recommendations; and

   (iii) Conclusions of Law and a listing of the Bylaws, Rules and Regulations, or policies of the Medical Staff or Hospital, or laws or regulations, in dispute with the majority opinion and a description of how these were or were not met.

VIII.N. DISPOSITION OF HEARING PANEL REPORT

VIII.N.1. Upon receipt of the Report of the Hearing Panel, the Chief of Staff shall promptly forward a complete copy to the affected Practitioner, the Chief Executive Officer and the Medical Executive Committee within two (2) working days. The Medical Executive Committee shall prepare a written comment to the Report of the Hearing Panel and shall promptly forward its comment to the affected practitioner, the Chief Executive Officer and the Board.

VIII.N.2. The Chief of Staff shall forward the Report of the Hearing Panel to the affected Practitioner by means of hand delivery or certified mail, return receipt requested;

VIII.N.3. The Medical Executive Committee shall forward a copy of its written comment on the Report of the Hearing Panel to the affected Practitioner by means of hand delivery or certified mail, return receipt requested;

VIII.O. APPEAL

VIII.O.1. Either party may request an appellate review of the order of the Hearing Panel by delivering a Notice of Appeal within ten (10) days of the Order of the Hearing Panel to the Chief Executive Officer of the Hospital.

VIII.O.2. The Notice of Appeal shall be delivered to the Chief Executive Officer either in person, or by certified mail. A Notice of Appeal shall:

a. Specify the party or parties taking the appeal;

b. Include a brief statement of the grounds for the appeal; and

c. Shall be served on the other party.

VIII.O.3. If an appeal is not requested within ten (10) days as provided herein, both parties shall be deemed to have accepted the recommendation of the Hearing Panel, and to have waived their rights to an appellate review. The decision of the Hearing Panel shall then be deemed a final action.

VIII.P. GROUNDS FOR APPEAL

The only grounds for appeal shall be:

VIII.P.1. A substantial failure to comply with the Bylaws, so as to deny due process or a fair hearing;

VIII.P.2. The decision was arbitrary, capricious, an abuse of discretion or not otherwise in accordance with law; or

VIII.P.3. The decision was unsupported by substantial evidence.

VIII.Q. NATURE OF APPELLATE REVIEW

VIII.Q.1. The Governing Board of the Teton County Hospital District is charged by statute with the operation of the Hospital. The Board of Trustees, by adoption of these Bylaws has made the conscious policy decision that knowing about the day-to-day operations of the Medical Staff constitutes better Hospital management than being the final appellate authority in Medical Staff matters. Consequently, the final appellate authority role is delegated as provided in W.S. § 35-2-910(d).

VIII.Q.2. The Chairperson of the Board shall, in compliance with W.S. §16-3-111 and W.S. § 35-2-910, appoint a Review Panel composed of not less than three (3) unbiased persons meeting the requirements of Section VIII.C.3., which shall be either members of the Board or other persons, including but not limited to persons outside the Hospital, to consider the entire record upon which the recommendation before it was made. Utilization of persons outside the Hospital shall not constitute a waiver of the confidentiality of the proceedings and information herein but, rather, shall be for the purpose of rendering an impartial decision by a neutral panel and/or for obtaining expertise in a particular specialty or subject.

VIII.Q.3. The Review conducted by the Review Panel shall be an on-the-record review.

VIII.Q.4. The party taking the appeal shall have twenty (20) days to deliver an appeal brief in support of their position to the Chief Executive Officer. The brief shall contain:

a. A title page;

b. A table of contents;

c. A table of cases and other authorities alphabetically arranged;

d. A statement of the issue presented for review;

e. A statement of the facts relevant to the issues presented for review;

f. An argument setting forth the appealing party(s) contentions with respect to the issues presented for review with citations to the authorities, statutes and parts of the record relied on;

g. A short conclusion stating the precise relief sought;

h. A signature of the party or the party(s) counsel; and

i. A certificate of service on the other party.

VIII.Q.5. The other party shall file a responsive brief within twenty (20) days of the appeal brief being delivered to the Chief Executive Officer. The responsive brief shall conform to the format set forth in Section VIII.Q.3. above.

VIII.Q.6. The Review Panel may set the matter for oral argument or decide the matter upon the briefs submitted.

VIII.Q.7. The Review Panel shall render a decision in writing within a reasonable time of reviewing the briefs or hearing the oral argument. If the order is reversed in whole or in part, the Review Panel shall render a recommendation.

VIII.Q.8. Upon receipt of the report of the Review Panel, the Chief Executive Officer shall promptly forward the report and recommendation to the affected Practitioner, the Medical Executive Committee, and the Board.

VIII.R. FINAL DECISION OF THE BOARD

VIII.R.1. To the extent the Board may participate pursuant to W.S. §16-3-111, the Board shall within a reasonable time after receipt of the Review Panel's recommendation or receipt of the Hearing Panel Report if no appeal is taken, render a final decision in writing and deliver copies to the affected Practitioner, the Chief of Staff and the Medical Executive Committee, in person or by certified mail, return receipt requested;

VIII.R.2. The Board may take one of the following actions regarding the recommendation of the Review Panel:

a. Affirm

b. Modify

c. Reverse

VIII.R.3. The final decision of the Board shall be effective immediately and shall not be subject to further administrative review.

VIII.R.4. If the Board cannot participate pursuant to W.S. §16-3-111, the report of the Review Panel shall become a final order.

VIII.S. RIGHT TO ONE APPEAL ONLY

VIII.S.1. The affected Practitioner shall be entitled to one (1) appellate review on any single matter.

VIII.S.2. If the Governing Board denies initial Medical Staff appointment or reappointment to an applicant, or revokes or limits the appointment and/or Clinical Privileges of a Medical Staff Member, that individual may not re-apply within five (5) years for appointment or Clinical Privileges.

VIII.T. CONFIDENTIALITY

All procedures described herein are considered confidential and legally privileged and any material, testimony and other documentation generated by or utilized in this process cannot be disclosed to persons outside the persons described in the process set out in this Article in accordance with the Health Care Quality Improvement Act of 1986 (42 U.S.C. §11101 et seq.) and Wyoming law (W.S. §§16-4-203, 35-2-609, 35-2-910 and 35-17-101 to 106), unless otherwise required or permitted by law.

IX. OFFICERS

IX.A. OFFICERS OF THE MEDICAL STAFF

IX.A.1. IDENTIFICATION

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

IX.A.2. QUALIFICATIONS

Officers must be Members of the active Medical Staff at the time of their nominations and election, and must remain in good standing during their term of office. Failure to maintain

IX.A.3. ELECTIONS

a. ELECTION OF REPRESENTATIVES TO THE MEDICAL EXECUTIVE COMMITTEE

(i) Except for the Chief Executive Officer and the Chief Nursing Officer , or their respective designees, , the Medical Executive Committee must be composed of active Medical Staff Members and shall be elected by Members of their respective specialty groups who are active Medical Staff Members with voting privileges at the time of the election.

(A) Elections shall occur at a formal meeting of each specialty group prior to the last quarterly meeting of the full Medical Staff. A written ballot shall be accepted, and may be submitted electronically, from eligible active Medical Staff Members who are unable to attend the specialty group meeting no later than the day of the meeting.

(B) In the event there is a tie between two or more nominees, voting physicians within the specialty group shall reach agreement on one representative, using whatever tie-breaking methodology is agreed upon within the specialty group. If the group cannot agree on a methodology for breaking a tie, the entire Medical Staff shall vote for that group's representative during the last quarterly meeting of the full Medical Staff.

(C) Results of these elections shall be documented in the respective specialty meeting minutes and provided to the Medical Staff during the last quarterly full Medical Staff meeting.

(D) Should a specialty group representative to the Medical Executive Committee resign, the Members of the specialty group will expeditiously elect another representative during the next formal meeting of the specialty group, with the same provisions outlined above.

b. ELECTION OF OFFICERS

(i) The officers of the Medical Staff shall be elected during the last quarterly meeting of the Medical Staff. Voting will require two-thirds (2/3) of the total membership of voting eligible active Medical Staff, either in person or by written absentee ballot, which may submitted electronically, prior to the meeting at which a vote is taken. A nominee shall be elected upon receiving a majority of all valid votes cast by written ballot, or by unanimous vote.

(A) If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, a majority vote of the current Medical Executive Committee shall decide the election by written ballot, or by unanimous vote, performed at the annual meeting.

(ii) The order of election will be:

(A) Chief of Staff

(B) Two (2) MEC Representatives At-Large

(C) Chief of Surgery, from the following elected individuals:

(1) Surgical – Orthopedic

(2) Surgical – Non-Orthopedic

(D) Chief of Medicine

(1) Medicine – Hospitalist

(2) Medicine – Internal Medicine, Family/General Practice, and Psychiatry

(E) Chief of Perinatal Services

(1) Pediatrics

(2) Obstetrics/Gynecology

(F) Vice-Chief of Staff

(G) Secretary/Treasurer

(iii) The Service Chief of the surgical and medicine services will be selected from the two representatives identified during the respective specialty meetings.

(iv) Two (2) MEC Representatives At-Large will be selected from the entire voting eligible active Medical Staff.

(v) The Chief of Staff will be elected from the entire voting eligible active Medical Staff and may, or may not, be a representative of a specialty group.

(vi) The nominees for Vice-Chief of Staff and Secretary/Treasurer will elected from the representatives elected during the meetings of their respective specialty groups and the two MEC Representatives at Large.

(A) The Vice-Chief of Staff and Secretary/Treasurer will also serve as representatives of their respective specialty groups.

(vii) Medical Staff Services shall facilitate the nomination and voting process, including absentee ballots, for all specialty groups and elected officers in accordance with these bylaws and any Medical Staff policies and procedures.

IX.A.4. TERM OF ELECTED OFFICE

The Chief of Staff and all other officers of the Medical Staff and elected representatives to the Medical Executive Committee shall serve a one (1) year term. The term shall commence on the first day of the Medical Staff year following the election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office.

IX.A.5. RECALL OF OFFICERS

Except as otherwise provided, recall of a Medical Staff officer may be initiated by the Medical Executive Committee or may be initiated by a petition signed by at least one-third (1/3) of the Members of the active Medical Staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds (2/3) vote of the active Medical Staff Members eligible to vote who cast votes at the special meeting in person or by absentee ballot which may be submitted prior to this meeting. The Medical Staff office shall facilitate the recall process in accordance with these bylaws and any Medical Staff policies and procedures.

Permissible bases for recall of an officer include, without limitation:

a. Failure to perform the duties of the position in a timely and appropriate manner;

b. Failure to properly represent the Medical Staff; or

c. Failure to comply with the basic responsibilities of Medical Staff membership, as enumerated in Section II.C. of these Bylaws.

IX.A.6. VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death, disability, resignation, removal of the officer, or such officer's loss of membership in the active Medical Staff. Vacancies, other than that of the Chief of Staff, shall be filled by appointment by unanimous vote by the Medical Executive Committee until voting by the active Medical Staff with voting privileges during the next quarterly Medical Staff meeting. In the event of a vacancy in the Office of Chief of Staff, a special election to fill the position shall occur as described in Section IX.A.3.b. during the next quarterly Medical Staff meeting.

IX.B. DUTIES OF OFFICERS

IX.B.1. CHIEF OF STAFF

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff. The duties of the Chief of Staff shall include, but not be limited to:

a. Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern to the hospital and Medical Staff;

b. Enforce the Medical Staff Bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

c. Call, preside at, and be responsible for the agenda of all meetings of the full Medical Staff;

d. Serve as Chief of the Medical Executive Committee;

e. Serve as an ex officio member of all other Medical Staff committees without vote, unless his or her membership is required by these Bylaws;

f. Serve as a representative to the Board of Trustees and interacting with the Chief Executive Officer and Board of Trustees in all matters of mutual concern within the Hospital;

g. Appoint members to all standing, special, and multidisciplinary Medical Staff committees, except the Medical Executive Committee;

h. Represent the views and policies of the Medical Staff to the Board of Trustees and to the Chief Executive Officer;

i. Attend all regularly scheduled meetings of the Board of Trustees;

j. Receive and interpreting the policies of the Board of Trustees to the Medical Staff, and reporting to the Board of Trustees on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibilities to provide medical care;

k. Act as a spokesperson for the Medical Staff in professional and public relations;

l. Perform such other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, or by the Medical Executive Committee;

m. Serve on liaison committees with the Board of Trustees and Hospital Administration, as well as outside certification, licensing and accreditation agencies; and

n. Be responsible for the publication and maintenance of a roster of Physicians available for emergency service at the Hospital, and on call for same, in accordance with the policies and procedures of the

Hospital and the Medical Staff. It shall be the obligation of all Members of the Medical Staff to comply with the assignments of the Chief of Staff for that purpose.

IX.B.2. VICE-CHIEF OF STAFF

The Vice-Chief of Staff shall:

a. Assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff;

b. Be a member of the Medical Executive Committee; and

c. Perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee.

IX.B.3. SECRETARY-TREASURER

The Secretary-Treasurer shall:

a. Serve as a member of the Medical Executive Committee;

b. Assume all duties and authority of the Chief of Staff and Vice Chief of Staff in their absence.

c. Perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee.

IX.C. CHAIN OF COMMAND FOR OFFICERS

The chain of command for the officers of the Medical Staff shall be:

a. Chief of Staff;

b. Vice-Chief of Staff;

c. Secretary-Treasurer;

d. Chief of Surgery or Chief of Medicine, as applicable

X. SERVICES

X.A. ORGANIZATION OF SERVICES

The Medical Staff of the Hospital will be divided into two major services: Medicine and Surgery.

A physician specializing in the area of Pathology, Radiology, or Emergency Medicine shall be given the option to choose to be in whichever service he or she feels is most appropriate. This selection may be made at the time of initial application, reapplication

or through a change of status request submitted to Medical Staff Services for Credentials Committee and Medical Executive Committee approval.

X.B. QUALIFICATIONS, SELECTION, AND TENURE OF SERVICE CHIEFS

X.B.1. Each Service Chief shall be board certified by an appropriate medical specialty or subspecialty board or shall establish comparable competence through the credentialing process.

X.B.2. Each Service Chief shall be elected by the Members of his or her service for a one (1) year term, as specified in Article IX.A.

X.B.3. Removal of the Service Chief during his or her term of office may be initiated as outlined in Section IX.A.5. of these bylaws.

X.C. FUNCTIONS OF SERVICE CHIEFS

Each Service Chief shall, in conjunction with the appropriate committees of the Medical Staff:

X.C.1. Be responsible for all clinically related activities within the service, including the continuous assessment and improvement of the quality of care and services provided;

X.C.2. Be responsible for all administratively related activities within the service, unless otherwise provided for by the Hospital;

X.C.3. Provide continuing surveillance of the professional performance of all individuals who have delineated Clinical Privileges within the service;

X.C.4. Recommend to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided within the service;

X.C.5. Recommend Clinical Privileges for each Member of the service;

X.C.6. Assess and recommend to the Hospital off-site sources for needed patient care services not provided within the organization;

X.C.7. Integrate the service into the primary functions of the Hospital;

X.C.8. Make recommendations for space and other resources needed by the service;

X.C.9. Be responsible for enforcement of the Medical Staff Bylaws and rules and of the Hospital District Bylaws, policies and procedures within his or her service;

X.C.10. Be responsible for implementation, within his or her service, of the actions taken by the Medical Executive Committee;

X.C.11. Participate in every phase of administration of his or her service, through cooperation with the nursing service and Hospital Administration, in matters affecting patient care, including personnel, supplies, special regulations, standing orders, and techniques; and

X.C.12. Assist in the preparation of such annual reports, including budgetary planning, pertaining to his or her service as may be requested by the Medical Executive Committee, the Chief Executive Officer, or the Board of Trustees.

X.D. FUNCTIONS OF THE SERVICE

X.D.1. Each service shall establish its own criteria, consistent with the policies of the Medical Staff and of the Board of Trustees, for its efficient and proven operations and the granting of Clinical Privileges in the service.

X.D.2. Under the direction of the Medical Executive Committee, the Quality and Performance Monitoring Committee (QPMC) shall conduct retrospective review of appropriate medical records. Cases thought to have particular educational value and specific issues and patterns that are identified in the course of chart review will be referred by QPMC to the service committee for discussion and action as appropriate.

X.D.3. Each service shall assure that clinical services are coordinated and integrated within the service as well as between the medicine and surgery services.

X.D.4. Each service will develop and implement policies and procedures that guide and support to provision of care, treatment and services.

X.D.5. Each service will have a role in making recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services.

X.D.6. Each service will have a role in determining the qualifications and competence of service personnel who are not licensed independent practitioners and who provide care, treatment and services.

X.D.7. Each service will continually assess and improve the quality of care, treatment and services.

X.D.8. Each service will maintain quality control programs, as appropriate.

X.D.9. Each service will have a role in the orientation and continuing education of all persons in the service.

X.E. ASSIGNMENT TO SERVICES

The Medical Executive Committee shall, after consideration of the recommendations of the clinical services, recommend initial service assignments for all Medical Staff Members, and for all other approved practitioners with Clinical Privileges.

XI. COMMITTEES

XI.A. GENERAL PROVISIONS

XI.A.1. TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed by the Chief of Staff for a term of one (1) year, and shall serve until the end of this period or until the member's successor is appointed unless the member shall sooner resign or be removed from the committee. Chief of Staff shall solicit volunteers for each committee and shall make his or her appointments based upon those volunteers to the greatest extent possible.

XI.A.2. QUORUM

A quorum for all committee meetings shall be a majority of voting members present, or other as defined by the committee.

XI.A.3. REMOVAL

If a member of a committee ceases to be a Staff Member in good standing, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed from committees by the Chief of Staff.

XI.A.4. VACANCIES

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; provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

XI.A.5. HOSPITAL REPRESENTATION

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

XI.A.6. VOTING ON COMMITTEES

Each Physician member on a Medical Staff committee will have one vote in deciding matters before the committee. The Physician members of a committee may vote at the beginning of each year, or during each year, to allow Consulting Staff, Non-Physician Professional Staff and/or Allied Health Professionals to vote on matters before the committee.

XI.A.7. CONFLICT OF INTEREST

If a committee member has, or is determined to have, a conflict of interest relating to a matter under consideration by the committee, then such committee member shall disclose the conflict of interest, absent himself or herself from the discussion, and not vote on the issue. Should a committee member raise an objection to another committee member voting on a matter under consideration by the committee, and should the committee member in question disagree that a conflict of interest exists, the vote shall be deferred until the entire committee decides if a conflict of interest exists.

XI.A.8. COMMITTEE CHAIR

The committee chair will be elected by the committee during the first meeting of the calendar year, except for the following:

a. The Chief of Medicine shall chair the Medical/ICU Service Committee

b. The Chief of Surgery shall chair the Surgical Service Committee

c. The Chief of Perinatal Service shall chair the Perinatal Committee.

Except as otherwise specified, the chair of a committee described in these Bylaws shall be a physician. At its discretion, each committee may vote to elect a committee co-chair.

XI.A.9. GUESTS

Guests may attend appropriate portions of a Medical Staff committee meeting at the discretion of the committee chair.

XI.A.10. EXECUTIVE SESSION

Committee members may call an executive session at any time during or at the conclusion of a committee meeting. The executive session will be limited to formal voting members of the committee, non-voting members may be included by invitation of the formal voting members of the committee.

XI.B. MEDICAL EXECUTIVE COMMITTEE

XI.B.1. COMPOSITION

The Medical Executive Committee shall be a standing committee empowered to act on behalf of the Medical Staff and shall consist of ten (10) or eleven (11) members of the Medical Staff, as listed below (ten members if the Chief of Staff is also a specialty group representative, and eleven members if the Chief of Staff is not a representative of a specialty group). The Chief Executive Officer and the Chief Nursing Officer, or their respective designees, shall serve as an ex-officio members. The committee will be chaired by the Chief of the Medical Staff.

a. Chief of the Medical Staff

b. Vice-Chief of Staff;

c. Secretary-Treasurer;

d. The Chief of Surgery, Chief of Medicine, and Chief of Perinatal Services, who were elected by their respective services, out of the applicable group of representatives, as outlined below.

   (i) Medicine – Hospitalist;

   (ii) Medicine - Internal Medicine, Family/General Practice, and Psychiatry;

   (iii) Pediatrics;

   (iv) Obstetrics/Gynecology;

   (v) Surgical – Orthopedic;

   (vi) Surgical – Non-Orthopedic;

   (vii) Emergency Medicine;

   (viii) Hospital-based specialties of Anesthesia, Pathology, and Radiology.

   (ix) Two MEC Representative at Large; eligible at large members shall be active Medical Staff members with voting privileges.

XI.B.2. REVIEW OF MEDICAL EXECUTIVE COMMITTEE COMPOSITION

The composition of the Medical Executive Committee should reflect the composition of the active Medical Staff. If the Medical Staff composition

changes such that the representation no longer approximates the relative distribution of medical specialties, revision of the structure of representation will be performed to reflect the changes in Medical Staff composition. This review will be performed by the Medical Executive Committee on an annual basis and any changes presented during a Medical Staff meeting for review and approval.

XI.B.3. DUTIES

The duties of the Medical Executive Committee shall be to:

a. Represent and be empowered to act on behalf of the Medical Staff between meetings of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

b. Coordinate the activities and general policies of the medical and surgical services;

c. Receive and act upon committee reports;

d. Implement policies of the Medical Staff not otherwise the responsibility of the medical and surgical services;

e. Be responsible for the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate and revise such activities;

f. Be responsible for creating a mechanism to assure the same level of quality of patient care by all individuals with delineated Clinical Privileges, within Medical Staff services, across services, and between Members and non-members of the Medical Staff who have delineated Clinical Privileges;

g. Provide liaison between the Medical Staff and the Chief Executive Officer and the Board of Trustees;

h. Recommend action to the Chief Executive Officer on matters of a medico-administrative nature;

i. Make recommendations on Hospital management matters to the Board of Trustees through the Chief Executive Officer and the Joint Committee on Quality & Safety;

j. Fulfill the Medical Staff's accountability to the Board of Trustees for the medical care rendered to patients in the Hospital;

k. Ensure that the Medical Staff is kept abreast of accreditation and governmental program requirements and informed of the accreditation status of the Hospital;

l. Make recommendations to the Board of Trustees on the appointment or reappointment of individuals to the Medical Staff and delineation of Clinical Privileges;

m. Periodically review information available regarding the performance and clinical competence of Medical Staff Members, including service recommendations and, as a result of such reviews, to make recommendations for reappointments and/or renewal of Clinical Privileges;

n. Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all Members of the Medical Staff, including the initiation of, and/or participation in, Medical Staff corrective or review measures when warranted;

o. Report, via the Chief of Staff, or designee, at each general Medical Staff business meeting;

p. In the absence of an Ethics Committee, function as the Ethics Committee for the Hospital, utilizing other individuals as consultants when deemed necessary;

q. Participate as a part of the hospital Quality Council Committee to review and evaluate the status and effectiveness of hospital-wide quality improvement activities. The Medical Executive Committee may make referrals to an individual, service or other committee in order to implement monitoring, perform further evaluation, implement corrective action(s), and/or provide evidence of problem-solving effectiveness.

r. The Medical Executive Committee shall make recommendations to the Board of Trustees regarding the following:

s. The structure of the Medical Staff

t. The mechanism used to review credentials and delineate Clinical Privileges

u. The organization of the quality assessment and improvement activities, the mechanism used to conduct, evaluate, and review such activities, the mechanism by which Medical Staff membership may be terminated, and the mechanism for fair hearing procedures.

XI.B.4. MEETINGS

The Medical Executive Committee shall meet as appropriate to fulfill the duties outlined in these Bylaws and shall maintain a permanent record of its proceedings and actions.

XI.B.5. VOTING

Members must be present to vote, either in person or via phone, on Medical Executive Committee matters. Proxy or absentee votes shall not be permitted.

XI.B.6. REPRESENTATION

A Medical Executive Committee member who anticipates being absent from a Medical Executive Committee meeting may arrange to send a representative of the same specialty in his or her place to the Medical Executive Committee meeting at the discretion of the Chief of Staff or the Chief of Staff's designee. Such representative shall be permitted to participate in discussion, but shall not be permitted to vote on committee matters.

XI.B.7. CONFLICT OF INTEREST

If a Medical Executive Committee member has, or is determined to have, a conflict of interest relating to a matter under consideration by the Medical Executive Committee, then such Medical Executive Committee member shall disclose the conflict of interest, absent himself or herself from the discussion, and not vote on the issue. Should a Medical Executive Committee member raise an objection to another Medical Executive Committee member voting on a matter under consideration by the Medical Executive Committee, and should the Medical Executive Committee member in question disagree that a conflict of interest exists, the vote shall be deferred until the entire Medical Executive Committee decides if a conflict of interest exists.

XI.B.8. RECALL OF MEDICAL EXECUTIVE COMMITTEE REPRESENTATIVES

a. Recall of a Medical Executive Committee (MEC) representative may be initiated by a member of the representative's specialty group or, in the case of an MEC member-at-large, by any member of the active Medical Staff eligible to vote in Medical Staff elections.

b. In the case of an MEC member who is elected by his or her specialty group, a request for recall shall be considered at a special meeting of the MEC member's specialty group.

c. Recall shall require a majority vote of those members of the MEC representative's specialty group who are eligible to vote.

d. In the case of an MEC member-at-large, recall shall be considered at a special meeting of the Members of the active Medical Staff who are eligible to vote. The physicians may cast their votes at the special meeting in person or by written ballot submitted prior to the special meeting.

e. Recall of an MEC member-at-large shall require a majority vote of the active Medical Staff Members eligible to vote who actually cast votes at the special meeting in person or by written ballot, which may be submitted electronically, prior to the special meeting.

f. Permissible bases for recall of an MEC representative include, but are not limited to:

(i) Failure to perform the duties of the position in a timely and appropriate manner; and/or

(ii) Failure to properly represent the members of the specialty group or the Medical Staff; and/or

(iii) Failure to comply with the basic responsibilities of Medical Staff membership as enumerated in Section II.C of these Bylaws.

(iv)

XI.B.9. MEDICAL EXECUTIVE COMMITTEE VACANCIES

Vacancies on the MEC that occur due to an MEC representative's death, disability, resignation, leave of absence or loss of membership on the active Medical Staff shall be filled in the same manner as the recall of an MEC representative--by special meeting of the representative's specialty group or the Members of the active Medical Staff who are eligible to vote, depending upon whether the MEC representative was elected by his or her specialty group or by the entire Medical Staff.

XI.C. CREDENTIALS COMMITTEE

XI.C.1. Composition

The Credentials Committee shall be a standing committee consisting of the Chief of Medicine or designee, Chief of Surgery or designee, Vice-Chief of Staff or designee, Medical Staff Secretary-Treasurer or designee and others as appointed by the Chief of Staff.

XI.C.2. Functions

The duties of the Credentials Committee shall be to:

a. Review credentials files, including new physicians, Non-Physician Professional Staff and Allied Health Professional Staff applications, reappointment applications, requests for change in privileges or Staff status;

b. Recommend action on credentials matters to the Medical Executive Committee;

c. Develop or revise credentialing policies and procedures for Medical Executive Committee action; and

d. Review and make recommendation to the Medical Executive Committee regarding the request for new Clinical Privileges and/or surgical technology.

XI.C.3. Meetings

The Credentials Committee shall meet as appropriate to fulfill the duties outlined in these Bylaws and maintain a permanent record of its proceedings and actions.

XI.D. THE PROFESSIONAL ACTIVITIES COMMITTEES

Unless otherwise specified, the following standing committees shall be appointed annually by the Chief of Staff.

XI.D.1. Pharmacy and Therapeutics/Nutritional Support Committee

a. Composition. The Pharmacy and Therapeutics/Nutritional Support Committee shall be composed of at least three (3) Members of the Medical Staff, the Hospital pharmacist, the Hospital dietitian, and at least one representative of the Nursing Service.

b. Meetings. The Pharmacy and Therapeutic/Nutritional Support Committee shall meet as appropriate to fulfill the duties outlined in these Bylaws and, shall maintain a permanent record of its findings, proceedings, and actions, and shall make a regular report to the Medical Executive Committee.

c. Functions. The Pharmacy and Therapeutics/Nutritional Support Committee shall have the following functions:

(i) Serve as an advisory group to the Medical Staff, and to the Hospital pharmacist on matters pertaining to the choice of available drugs;

(ii) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(iii) Develop, and annually review, a formulary or drug list for use in the Hospital;

(iv) Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

(v) Evaluate clinical data concerning new drugs, or preparations, requested for use in the Hospital;

(vi) Establish standards concerning the use and control of investigational drugs, and of research in the use of recognized drugs;

(vii) Review the clinical use of drugs in the Hospital, including antibiotics, non-antibiotics and anesthetic agents, both inpatient and outpatient;

(viii) Coordinate action on findings from the committee and the Medical Staff;

(ix) Review and report adverse drug reactions; drug recalls; formulary additions/deletions; medication variances; policies and procedures, including drug selection, distribution, handling, use and administration; policy and procedure variances; food drug interaction; and approve/modify criteria for monitoring quality of services provided by pharmacy. The committee will monitor data presented, draw conclusions, make recommendations, carry out actions and follow-up actions;

(x) Report Drug Usage Evaluation on a quarterly basis;

(xi) Provide a standard of care for nutritional support as a service of the Hospital;

(xii) Monitor patients receiving supplemental nutrition;

(xiii) Provide information and assistance to Hospital staff through in-service and resource material; and

(xiv) Monitor admissions and screen cases for potential nutritional risk.

XI.D.2. Emergency Services Committee

a. Composition. The Emergency Department Committee shall be composed of all emergency physicians, appropriate AHPs, one representative each from Internal Medicine, Family Practice and Surgery, any other Physicians interested in serving, at least one representative of the Nursing Service, and the Chief Executive Officer or designee as an ex-officio member.

b. Meetings. The Emergency Department Committee shall meet as appropriate to fulfill the duties outlined in these Bylaws and maintain a permanent record of its findings, proceedings and actions, and shall report regularly to the Medical Executive Committee.

c. Functions. The duties and functions of the Emergency Department Committee shall be to:

(i) Implement the Hospital's basic plan for the delivery of ambulatory and emergency services;

(ii) Coordinate with local emergency medical services (EMS), to promote efficient and effective pre-hospital care for ill and injured patients;

(iii) Review selected emergency/outpatient cases to evaluate the appropriateness and quality of care as necessary; and

(iv) Perform quality assurance/quality improvement peer review activities.

XI.D.3. Medical Education Committee

a. Composition. This Medical Education Committee shall be composed of at least three (3) Physicians, the Hospital's in-service director, Medical Staff Coordinator and other interested Practitioners.

b. Function. The Medical Education Committee shall be responsible for overseeing the preceptee program, including the following:

(i) Soliciting input from preceptees and the Practitioners supervising preceptees regarding the safety and quality of patient care, treatment and services provided by, and the related educational and supervisory needs of, the preceptees;

(ii) Receiving input from Medical Staff Coordinator about the quality of care, treatment and services and educational needs of the preceptees;

(iii) Reviewing preceptees' evaluations of their clinical rotations at the Hospital and reviewing supervising Practitioners' evaluations of the preceptees to identify problem trends;

(iv) Recommending and when appropriate implementing improvements to the program based upon the above input; and

(v) Communicating with the Medical Staff and Board of Trustees regarding the safety and quality of patient care, treatment and services provided by, and the related educational and supervisory needs of, the preceptees.

XI.D.4. Medical Staff Bylaws Committee

a. Composition. The Medical Staff Bylaws Committee shall be composed of at least four (4) Members of the active Staff.

b. Function. The Medical Staff Bylaws Committee shall:

(i) Review Bylaws and rules and regulations of the Medical Staff and procedures and forms promulgated in connection therewith when necessary. It shall submit recommendations for changes in these documents to the Medical Executive Committee, the Medical Staff, and the Board of Trustees; and

(ii) Act on all matters specified above, as may be referred by the Board of Trustees, Joint Conference Committee, Medical Staff committees or Staff Members.

XI.D.5. Perinatal Committee

a. Composition. The Perinatal Committee shall be composed of those Practitioners involved in practicing obstetrics and newborn pediatrics,

as well as appropriate representatives from anesthesia service and the Nursing Staff, including the Obstetrical Director, or designee. The committee will be chaired by the Chief of Perinatal Service.

b. Meetings. The Perinatal Committee will meet as appropriate to fulfill the duties outlined in these Bylaws and shall present reports of its meetings to the Medical Executive Committee.

c. Function. The functions of the Perinatal Committee will be to:

(i) Review policies and procedures regarding maternal and newborn perinatal care;

(ii) Provide appropriate continuing education for nurses and other individuals involved in the care of peripartum women and newborns;

(iii) Be particularly attentive to perinatal mortality, infection control, newborn resuscitation, and obstetric statistics; and

(iv) Perform perinatal quality assurance/quality improvement peer review activities

XI.D.6. Medical Service/Intensive Care Unit (ICU) Committee

a. Composition. The committee will be chaired by the Chief of Medicine. Members will include all Physicians assigned to the medical service, appropriate AHPs, representatives of the Nursing Staff, ancillary services representative, CEO and risk manager. One member will be appointed by the chief of medicine, one member appointed by the chief of surgery, one member appointed by the chief of anesthesiology, one emergency department Physician, a representative from respiratory therapy and the ICU coordinator. An EMT representative may be appointed as an ex-officio member.

b. Meetings. The Medical Service/ICU Committee will meet as appropriate to fulfill the duties outlined in these Bylaws, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report regularly to the Medical Executive Committee.

c. Functions. The functions of the Medical Service/ICU Committee will be to:

(i) Review and approve policies and procedures regarding ICU and non-surgical care;

(ii) Discuss any Hospital procedures that would affect the Medical Service/ICU.

(iii) Organize and implement appropriate continuing education for those involved in the care of ICU and non-surgical patients;

(iv) Coordinate Basic and Advanced Cardiac Life Support Classes and practice drills;

(v) Arrange for continuation of CPR certification classes for Staff Members, Hospital Staff, and other interested individuals, via the in-service coordinator;

(vi) Maintain, and periodically revise, the 'CODE BLUE' policy, and conduct mock 'CODE BLUE' drills for Staff practice;

(vii) Supervise and arrange for the organization of crash carts for appropriate areas of the Hospital;

(viii) Be particularly attentive to mortality, morbidity, infection control;

(ix) Perform quality assurance/quality improvement peer review activities within the ICU and non-surgical area; and

(x) Report to the appropriate Medical Staff and Hospital committees, and to the Hospital Administration.

XI.D.7. Surgical Service Committee

a. Composition. The Surgical Service Committee will be composed of all Physicians assigned to the surgical service, appropriate AHPs, representatives of the Nursing Staff including operating room, CEO and risk manager. The committee will be chaired by the Chief of Surgery.

b. Meetings. The Surgical Service Committee will meet as appropriate to fulfill the duties outlined in these Bylaws and shall maintain a permanent record of its findings, proceedings and actions, and shall make a report regularly to the Medical Executive Committee.

c. Functions. The functions of the Surgical Service Committee will be to:

(i) Review policies and procedures regarding surgical care;

(ii) Provide appropriate continuing education for nurses and other individuals involved in the care of surgical patients;

(iii) Be particularly attentive to mortality, morbidity, and infection control; and

(iv) Perform quality assurance/quality improvement peer review activities within the surgical area.

XI.D.8. Ad Hoc Committees

The Medical Staff as a whole, and the Medical Executive Committee, may by resolution and majority vote, create special or ad hoc committees to perform specified functions or functions of short duration.

XI.E. MEDICAL STAFF—HOSPITAL JOINT COMMITTEES

XI.E.1. Infection Control Committee

a. Composition. The Infection Control Committee will be composed of three Members of the active Medical Staff, at least one representative of the Nursing Service, and one representative from Hospital Administration.

b. Meetings. The Infection Control Committee will meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall report regularly to the Medical Executive Committee.

c. Function. The Infection Control Committee shall be responsible for the surveillance of nosocomial infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities, including:

   (i) Operating rooms, delivery rooms, recovery rooms, special care units, primary care unit, transitional care unit, and the Living Center;

   (ii) Sterilization procedures by heat, chemicals or otherwise;

   (iii) Isolation procedures;

   (iv) Monitoring of Hospital personnel for hazards to patients and hazards from patients;

   (v) Disposal of infectious material; and

   (vi) Other situations as requested by the Medical Executive Committee.

XI.E.2. Safety Committee

a. Composition. The Safety Committee is an interdisciplinary committee, with Hospital Staff members appointed by the Chief Executive Officer, and one Member of the Medical Staff, appointed by the Chief of Staff, who will serve in an advisory capacity to the committee. The chair will be appointed by the Hospital Chief Executive Officer.

b. Meetings. The Safety Committee will meet at least monthly, shall maintain a permanent record of its proceedings, and shall report

regularly to the Medical Executive Committee and Joint Conference Committee.

c. Function. The functions of the Safety Committee shall be to:

(i) Review safety-related items and also to review incident reports, such as employee injuries, needle injuries, etc.;

(ii) Develop written policies and procedures designed to enhance safety within the Hospital, and on its grounds, to the maximum degree possible; and

(iii) Be familiar with local, state, and federal safety regulations applicable to the Hospital, and develop a reference library of pertinent safety-related information. This information will be transmitted to Hospital employees and included in any Hospital employee orientation program.

XI.E.3. Radiation Safety Committee

a. Composition. The Radiation Safety Committee is a joint committee including the Radiation Safety Officer (who is a Staff radiologist), an administrative representative of the Radiology Department, a nuclear medicine technician and a representative from Nursing Service.

b. Meetings. The Radiation Safety Committee will meet at least quarterly. The Radiation Safety Committee will keep a permanent record of its proceedings and shall report to the appropriate Medical Staff committee(s) regularly.

c. Function. The Radiation Safety Committee will perform the following functions:

(i) Ensure that all individuals who work with or in the vicinity of radioactive material have sufficient training and experience to enable them to perform their duties safely and in accordance with NRC regulations and the conditions of the license; and

(ii) Ensure that the use of radioactive material is conducted in a safe manner and in accordance with NRC regulations and the conditions of the license.

d. Duties.

(i) Be responsible for monitoring the institutional program to maintain individual and collective doses as low as reasonably achievable;

(ii) Review, on the basis of safety and with regard to the training and experience, and approve or disapprove any individual who is to be listed as an authorized user or the Radiation Safety

Officer before submitting a license application or request for amendment or renewal.

(iii) Review on the basis of safety, and approve or disapprove, each proposed method of use of by-product material.

(iv) Review on the basis of safety, and approve or disapprove, with the advice and consent of the Radiation Safety Officer and the management representative, procedures and radiation safety program changes.

(v) Review quarterly, with the assistance of the Radiation Safety Officer, all incidents involving by-product material with respect to cause and subsequent actions taken.

(vi) Review annually, with the assistance of the Radiation Safety Officer, the byproduct material program; and,

(vii) Establish a table of investigational levels for occupational dose that, when exceeded, will initiate investigation and considerations of the action by the Radiation Safety Officer.

XI.F. JOINT COMMITTEE ON QUALITY AND SAFETY

XI.F.1. <u>Composition</u>.

The Joint Committee on Quality and Safety shall be a standing committee, composed of three (3) Members of the Medical Staff and three (3) members of the Board of Trustees. The Chief Executive Officer, Chief Nursing Officer, Director of Patient and Safety and Quality and Medical Director for Quality Affairs shall be ex-officio members without voting privileges. The representatives from the Medical Staff shall include the Chief of Staff and one (1) additional Medical Executive Committee Member as appointed by the Chief of Staff.

XI.F.2. <u>Meetings</u>.

The Joint Committee on Quality and Safety shall meet at least four (4) times a year, and shall transmit written reports of its activities to the Board of Trustees and to the Medical Executive Committee. The Joint Committee on Quality and Safety shall also meet at the call of the Chief Executive Officer, the Board of Trustees, or the Chief of Staff.

XI.F.3. <u>Functions</u>.

The Joint Committee on Quality and Safety shall conduct itself as a forum for the discussion of matters of Hospital policy and practice,

especially those pertaining to efficient and effective patient care, and shall provide liaison with the Board of Trustees and the Chief Executive Officer. The leadership of the organization-wide performance improvement initiative is provided by the Joint Committee on Quality and Safety. The committee determines strategic direction and vision for the organization's performance improvement efforts. It shall have the following specific duties:

a. Accreditation. It shall be responsible for acquisition and maintenance of Hospital accreditation. For this purpose, it shall form a subcommittee that includes key Hospital personnel who are important in implementing the accreditation program. From time to time, it shall require that the accrediting body survey forms be used as a review method to estimate the accreditation status of the Hospital. It shall supervise a trial survey between regular accreditation surveys, for purposes of constructive self-criticism. It shall identify areas of suspected non-compliance with accrediting body standards, and shall make recommendations to the Medical Staff and Board of Trustees for appropriate action.

b. Bylaws, Rules and Regulations. It shall receive and recommend to the Board of Trustees the adoption of amendments, or repeal of rules and regulations governing the Medical Staff.

c. Credentialing Recommendations. It shall receive recommendations from the Medical Staff and make final recommendations to the Board of Trustees on all appointments to the Medical Staff and on assignments of responsibilities within the Medical Staff including definition of the scope of privileges and termination of privileges.

    (i) Performance/Quality Improvement. It shall assess organization-wide needs for performance improvement efforts through periodic review of the following:

        (A) Clinical and health status performance indicators (medical, surgical, community-wide);

        (B) Direct requests from Medical Staff, Hospital staff, patients/families, community and others, either directly or via Performance Improvement Forms;

        (C) Trends in customer satisfaction information, including patient complaints and Press-Ganey survey results;

        (D) Benchmarking comparisons with other organizations; and

        (E) Findings of surveys and reviews by external bodies.

    (ii) It shall identify the highest priority performance improvement opportunities;

(iii) It shall promote, support and empower performance improvement project teams;

(iv) It shall determine the need for and facilitate the provision of training, education and support materials in performance improvement;

(v) It shall provide general oversight and support for departmental, organization-wide and Medical Staff performance improvement and monitoring activities;

(vi) It shall communicate/report performance improvement activities, results and requirements to Board of Trustees, Medical Staff, Hospital staff and community as appropriate; and

(vii) It shall maintain strict confidentiality regarding sensitive information as provided for in hospital, Medical Staff and Board of Trustees policies, bylaws, rules and regulations.

XI.G. BEHAVIORAL SERVICES COMMITTEE

XI.G.1. Composition.

The Behavioral Services Committee shall be composed of all psychologists, appropriate Allied Mental Health Professionals and community representatives affiliated with local behavioral services. Psychologists shall be participating and voting members of the executive committee.

XI.G.2. Meetings.

The Behavioral Services Committee shall meet as appropriate to fulfill the duties outlined in these Bylaws and shall maintain a permanent record of its findings, proceedings and actions, and shall make a report regularly to the Medical Executive Committee.

XI.G.3. Functions.

The functions of the Behavioral Services Committee will be to:

a. Serve as an advisory committee to the Medical Executive Committee and Hospital Administration regarding all aspects of the practice of psychology in the Hospital;

b. Take up other relevant business as requested by the Medical Executive Committee or Hospital Administration.

XI.G.4. The Behavioral Services Executive Committee shall meet directly following the Behavioral Services Committee and will:

a. Review credentials of psychologists and Allied Mental Health Professional candidates for Hospital privileges;

b. Conduct performance review of the psychologists and Allied Mental Health Professionals; and

c. Develop, review, update and recommend to the Behavioral Services Committee policies, procedures and changes to the Medical Staff Bylaws and rules and regulations having to do with the practice of psychology services.

XI.H. QUALITY AND PERFORMANCE MONITORING COMMITTEE

XI.H.1. Composition.

The Quality and Performance Monitoring Committee shall be an interdisciplinary committee with Physician representation roughly parallel to the specialty composition of the Medical Staff although no definitive representation from any individual group shall be required. The committee will include representation from nursing and Hospital management.

XI.H.2. Meetings.

The Quality and Performance Monitoring Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report regularly to the Medical Executive Committee and Quality Council.

XI.H.3. Functions.

The Quality and Performance Monitoring Committee shall function as the primary Hospital peer review committee under the direction of the Medical Executive Committee. The functions of the Quality and Performance Monitoring Committee will be to:

a. Reengineer the Medical Staff's approach to peer review/quality monitoring and to meeting all applicable standards;

b. Monitor overall clinical performance and individual Practitioners' performance;

c. Develop, review and report type 1, 2, and 3 performance indicators; and

d. Advise the Medical Executive Committee and provide reports to relevant Hospital and Medical Staff leaders.

XI.I. TRAUMA PROGRAM AND TRAUMA COMMITTEE

XI.I.1. Trauma Program.

The trauma program shall be established and recognized by the Medical Staff and Hospital administration. The trauma program shall come under the overall organization and direction of a general surgeon or emergency Physician who is trained, experienced and committed to the care of the injured patient.

XI.I.2. Trauma Program Director.

The director shall be a board certified surgeon or board certified emergency Physician with experience in trauma care. The director will be given administrative support to implement the requirements specified by the Wyoming Trauma Plan.

XI.I.3. Trauma Team.

The Hospital will designate a trauma team and shall have a policy describing the respective roles of all personnel on the trauma team. The team leader shall be a qualified Physician who is clinically capable in all aspects of trauma resuscitation. The trauma team may include but not be limited to surgeons, anesthesiologists, emergency Physicians, family Physicians, laboratory technicians, registered nurses, physician specialists as dictated by clinical needs, prehospital care providers, radiology technicians, respiratory therapists and social services personnel.

XI.I.4. Trauma Nurse Coordinator.

The Hospital will designate a trauma nurse coordinator. Working in conjunction with the trauma program director, the trauma nurse coordinator shall organize the program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The trauma nurse coordinator is responsible for coordinating optimal patient care for trauma patients.

XI.I.5. Multidisciplinary Trauma Committee.

a. Composition. The trauma committee shall be a multidisciplinary committee which may include but not be limited to the following representatives: administration, anesthesia, emergency department, general surgery, intensive care, laboratory, medical records, nursing, operating room, orthopedics, pediatrics prehospital care providers, radiology, rehabilitation, respiratory therapy and trauma nurse coordinator.

b. Meetings. The trauma committee shall meet as appropriate to fulfill the duties outlined in these Bylaws and shall maintain a permanent record of its findings, proceedings and actions, and shall make a report regularly to the Medical Executive Committee.

c. Functions. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The major focus shall be quality improvement activities, policy development, communication among all team members, development of standards of care, education and outreach program and work with appropriate groups for injury prevention. The clinical managers (or designees) of the organizational areas involved with trauma care shall play an active role with the committee.

XII. MEDICAL STAFF MEETINGS

XII.A. REGULAR MEETINGS

XII.A.1. Meetings of the Medical Staff shall be held quarterly or more frequently to conduct Medical Staff business, at the discretion of the Medical Staff.

XII.A.2. The December Medical Staff meeting shall be the annual Staff meeting, at which election of officers for the ensuing year shall be conducted.

XII.A.3. The Medical Executive Committee shall, by standing resolution, designate the time and place for all regular Medical Staff meetings. Notice of the original resolution, and any changes thereto, shall be given to each Member of the Staff, in the same manner as provided in Section XII.B. for the notice of a special meeting.

XII.A.4. The meetings will be organized, and decorum maintained as specified in these Bylaws for committee/service meetings.

XII.B. SPECIAL MEETINGS

XII.B.1. The Chief of Staff, the Medical Executive Committee, or not less than one-fourth (1/4) of the Members of the active Medical Staff may, at any time, file a written request with the Chief of Staff that within fourteen (14) days of the filing of such request, a special meeting of the Medical Staff be called. The Medical Executive Committee shall designate the time and place of any such special meeting.

XII.B.2. Written or printed notice, stating the business to be discussed, place, day, and hour of any special meeting of the Medical Staff

shall be delivered, either personally or by mail, to each Member of the active Medical Staff, not less than three (3), nor more than fourteen (14) days before the date of such special meeting, by or at the direction of the Chief of Staff (or other persons authorized to call the meeting). If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each active Medical Staff Member at his or her address as it appears on the records of the Hospital. Notice may also be sent to Members of other Medical Staff groups who have so requested. The attendance of a Member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting.

XII.B.3. No business shall be transacted at any special meeting of the Medical Staff, except that stated in the notice calling the meeting.

XII.C. QUORUM

The presence of fifty percent (50%) of the membership of the active Medical Staff with voting privileges shall constitute a quorum, except that a quorum for committee or service meetings may be changed, as specified in Section XIII.D. of these Bylaws.

XII.D. ATTENDANCE

XII.D.1. Each calendar year, each Member of the active Medical Staff shall be required to attend 50% of a combined total of scheduled or rescheduled Medical Staff meetings and meetings of Medical Staff committees to which the Member is appointed. Meetings missed which have been scheduled with less than thirty (30) days' notice shall not be counted in computing attendance percentages.

XII.D.2. Attendance at each Medical Staff meeting shall be recorded. A running monthly summary will be kept by the Medical Staff Coordinator, and an up-to-date copy submitted to the Medical Executive Committee prior to each annual meeting.

XII.D.3. The Medical Staff Office will submit a complete attendance record of each active and provisional Medical Staff Member to the Medical Executive Committee before the annual election of MEC representatives in November. If the active Staff Member has not met the 50% attendance requirement, his or her eligibility to vote (1) in the election of MEC representative(s); (2) in the election of Medical Staff officers and Chiefs of Service; (3) on Bylaws or rules and regulations changes; and (4) on any other matter that comes up before the entire Medical Staff, will be restricted for twelve (12) months, at which time his or her meeting attendance for the past twelve months will be assessed to determine his or her eligibility to

vote on those items listed above. The Staff Member will continue to have voting privileges at the meetings of those committees of which he or she is a member.

XII.D.4. The Chief of Staff (or his/her designee who is chairing the meeting) may invite guests to attend appropriate portions of the Medical Staff meetings.

XII.E. SPECIAL ATTENDANCE REQUIREMENTS

XII.E.1. A Staff Member whose patient's clinical course is scheduled for a discussion at a regular service or committee meeting shall be so notified, and shall be expected to attend such meeting. If such Staff Member is not otherwise required to attend the meeting, the chair of the involved committee shall give the Staff Member advance, written notice of the time and place of the meeting at which his or her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the Staff Member shall so state and shall include a statement that his or her attendance is mandatory at the meeting at which the alleged deviation is to be discussed.

XII.E.2. Failure by a Staff Member to attend any meeting with respect to which he or she was given notice that attendance was mandatory, unless excused by the Medical Executive Committee upon a showing of good cause, may result in an automatic suspension of all, or of such portion of the Staff Member's Clinical Privileges as the Medical Executive Committee may direct, as provided for at Section VII.D.3. In all other cases, if the Staff Member shall make a timely request for postponement, supported by an adequate showing that his or her absence will be unavoidable, such presentation may be postponed by the Chief of Staff, or by Medical Executive Committee if the Chief of Staff is the Staff Member involved. Such postponement shall be for no longer than until the next regular meeting, otherwise the pertinent clinical information shall be presented and discussed as scheduled.

XII.F. CONFLICT OF INTEREST

If a Medical Staff Member has, or is determined to have, a conflict of interest relating to the matter under consideration, then such Medical Staff Member shall disclose the conflict of interest, absent himself or herself from the discussion, and not vote on the issue. Should a Medical Staff Member raise an objection to another Medical Staff Member voting on a matter under consideration by the Medical Staff due to a conflict of interest, and should the Medical Staff Member in question disagree that a conflict of interest exists, the vote shall be deferred until the entire Medical Staff who are present decide if a conflict of interest exists.

XIII. <u>COMMITTEE AND SERVICE MEETINGS</u>

XIII.A. REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings without notice, other than such resolution.

XIII.B. SPECIAL MEETINGS

A special meeting of any committee or service may be called by, or at the request of, the chair thereof, by the Chief of the Staff, or by one-third (1/3) of the committee's current Physician Members, but by not less than two (2) Physician Members.

XIII.C. NOTICE OF MEETINGS

Written or oral notice, stating the place, day, and hour of any regular or special meeting, not held pursuant to resolution, shall be given to each member of the committee or service, not less than five (5) days or more than thirty (30) days before the time of such meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail, addressed to the member at his or her address as it appears on the records of the Hospital, with postage thereon prepaid.

XIII.D. QUORUM FOR COMMITTEE MEETINGS

Three (3) or more voting members will constitute a quorum for the transaction of business at any Medical Staff or Committee meeting. If less than such a number is present, either in person or via phone, the meeting shall be adjourned.

XIII.E. MANNER OF ACTION

The action of a majority of the members present at a meeting, at which a quorum is present, shall be the action of a committee. Action may be taken without a meeting by unanimous consent, in writing or via email setting forth the action so taken, and signed by each member entitled to vote thereat.

XIII.F. RIGHTS OF *EX OFFICIO* MEMBERS

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum, nor shall they have the right to vote.

XIII.G. MINUTES

Minutes of each regular and special meeting of a committee shall be prepared by a Medical Staff Office staff member, and shall include a record of the attendance, matters discussed and the vote taken on each matter. The Medical Staff Office shall provide the proposed meeting minutes to the committee for review during the next scheduled meeting. Committee minutes shall be condensed into a meeting report and forwarded to

the Medical Executive Committee and other committee meetings as deemed applicable for information. The Medical Staff Office shall maintain a permanent file of the agenda and minutes of each Medical Staff meeting.

XIV. CONFIDENTIALITY, IMMUNITY, AND RELEASES

XIV.A. GENERAL

The following shall be express conditions to any Practitioner's application for, or exercise of, Clinical Privileges at the Hospital. All acts, communications, reports, recommendations or disclosures addressed in this Article XIV shall pertain to those acts, communications, reports, recommendations or disclosures performed by Members of the Staff and Board of Trustees ONLY while functioning in some official capacity for the Hospital.

XIV.B. IMMUNITY FROM LIABILITY

Federal and State Law, including the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11101 et seq, and W.S. §§ 35-17-101 to 106, grant immunity from liability for participating in Medical Staff functions and deems the proceedings confidential. To the maximum extent allowed by law, SJMC adopts the immunity and confidentiality of such statutes and their effectuating regulations.

XIV.C. RELEASES

Each Member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article XIV. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article XIV.

XIV.D. CONFIDENTIALITY OF INFORMATION

XIV.D.1. General

a. All reports, findings, proceedings and data relating to the evaluation or improvement of the quality of care rendered in the Hospital are confidential and privileged, and are not subject to discovery or introduction into evidence in any civil action.

b. No person in attendance at any committee meeting or other proceeding pursuant to the activities described in Section XIV.B. of these Bylaws shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the meeting or proceeding or as to any findings, recommendations, evaluations, opinions, or other actions taken at such a meeting or proceeding.

XIV.D.2. Breach of Confidentiality

Inasmuch as effective peer review and consideration of the qualifications of Members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of committees, except in conjunction with other Hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

XV. MEDICAL RECORDS

XV.A. The following requirements apply to the inpatient and outpatient history and physical examination:

XV.A.1. The inpatient history and physical shall contain the following:

a. Chief complaint

b. Initial diagnosis

c. Proposed procedure if applicable

d. Description of allergies

e. Description of the present illness

f. Relevant past medical, social and family history

g. Listing of current medications

h. Comprehensive current physical assessment to include review of major body systems

i. Assessment

j. Plan of care

XV.A.2. An outpatient history and physical is required for invasive or high risk procedures. The outpatient history and physical shall include the following:

a. Chief complaint

b. Initial diagnosis

c. Proposed procedure

d. Description of allergies

e. Relevant past medical history

f. Listing of current medications

g. Current physical assessment

XV.A.3. When the history and physical examination is performed and reported by a medical student, resident, fellow, other preceptee or Member of the Allied Health Professional Staff, the attending Physician shall document supervision by co-signing the history and physical upon the attending Physician's next visit to the patient.

XV.A.4. Patients admitted for dental care are the dual responsibility of the dentist and/or oral surgeon and a Physician Member of the Medical Staff with admitting privileges, and shall receive the same basic medical appraisal as patients admitted for other services. This includes an admission history and physical examination and an evaluation of the overall medical risk, with documentation of the findings in the medical record. The dentist and/or oral surgeon is responsible for a detailed dental history and physical as outlined in hospital approved guidelines, a detailed description of the exam of the oral cavity, and a preoperative diagnosis.

XV.A.5. Patients admitted for podiatric care are the dual responsibility of the podiatrist and a Physician Member of the Medical Staff with admitting privileges, and shall receive the same basic medical appraisal as patients admitted for other services. This includes an admission history and physical examination and an evaluation of the overall medical risk, with documentation of the findings in the medical record. The podiatrist is responsible for a detailed podiatric history and physical as outlined in hospital approved guidelines, a detailed description of the exam of the affected area, and a preoperative diagnosis.

XV.A.6. A history and physical examination for each patient shall be completed and documented in the medical record no more than 30 days before or twenty-four (24) hours after admission or registration, and prior to any high-risk procedure, surgery, procedures requiring anesthesia services, or other procedures requiring an H&P. In cases of emergency surgery, the history and physical examination shall be performed and documented as soon as possible after admission. In addition, the Physician must also provide an update to the patient's condition in the progress note prior to surgery or procedure.

a. An H&P completed within 30 days prior to admission or registration shall include an updated entry in the medical record documenting an examination for any change in the patient's current medical condition completed by a doctor of medicine or osteopathy, maxillofacial surgeon or other qualified individual who has been granted these privileges by the Medical Staff in accordance with State law.

b. Any H&P update of the patient's current medical condition shall document:

(i) That the patient has been examined;

(ii) That the H&P has been reviewed; and

(iii) Any changes in the patient's condition; or,

(iv) That "no change" has occurred in the patient's condition since the H&P was completed.

c. The examination and update of the patient's current medical condition shall be competed and placed in the medical record within 24 hours after admission or registration, and prior to any high-risk procedure, surgery, procedure requiring anesthesia services, or other procedures requiring an H&P.

XV.A.7. If the patient is going to surgery within the first 24 hours of admission, the update to the patient's condition and pre-anesthesia assessment could be accomplished as a combined activity.

XV.A.8. For obstetrical admission, the entire prenatal record can be used as the history and physical, with an entry no later than 30 days before the inpatient admission. An interim note must also be entered in the progress notes within 24 hours of admission or prior to surgery (if applicable).

XV.A.9. In an emergency, when there is not time to record the complete history and physical examination, a progress or admission note describing a brief history, appropriate physical findings, and the preoperative diagnosis shall be recorded in the medical record prior to surgery.

XV.A.10. When a consult that contains all the elements of a comprehensive history and physical is to be used as the history and physical for a surgical patient, the attending primary surgeon must dictate the surgical-specific portion of the history and physical and refer to the consultation for the balance of the document. A consult over 30 days old falls into the category of an over 30 day old history and physical, and a new history and physical must be dictated.

XVI. RULES AND REGULATIONS AND POLICIES OF THE MEDICAL STAFF

XVI.A. The Medical Staff shall adopt such Rules and Regulations and Policies as may be necessary to implement more specifically the general principles found within these Bylaws, and shall be subject to the approval of the Board of Trustees.

XVI.B. These Rules and Regulations and Policies shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each practitioner in the Hospital.

XVI.C. Rules and Regulations shall be a part of these Bylaws. New Rules and Regulations may be proposed, or existing Rules and Regulations may be amended or repealed:

XVI.C.1. At any regular meeting of the Medical Staff at which a quorum is present, and without previous notice; or

XVI.C.2. At any special meeting on notice, by a majority vote of those Members of the active Medical Staff with voting privileges who are present; or

XVI.C.3. Via written ballot or email vote.

Policies shall be part of these Bylaws except that they may be proposed, approved and/or amended at any meeting of the Medical Executive Committee, or in the same manner as Rules and Regulations. Comments may be submitted if any Medical Staff Member who is eligible to vote on the Rule, Regulation or Policy, cannot be present at the meeting at which the proposed Rule, Regulation or Policy will be acted on..

XVI.D. **RULES, REGULATIONS AND/OR POLICIES, AND/OR AMENDMENTS THERETO**, shall become effective upon approval by the Board of Trustees. Neither body (Medical Staff or Board of Trustees) may unilaterally amend the rules, regulations and/or policies of the Medical Staff.

XVI.E. **COMMUNICATION OF RULES, REGULATIONS AND/OR POLICIES BEFORE TRANSMISSION TO BOARD**.

XVI.E.1. Rules, Regulations and/or Policies, or amendments thereto, proposed and approved by the Medical Staff pursuant to Section XVI.C.1, 2 or 3, above, shall be communicated to the Medical Executive Committee prior to being transmitted to the Board for consideration. If the Medical Executive Committee adopts a policy or an amendment to any policy, such adoption shall be communicated to the Medical Staff prior to the policy or amendment being transmitted to the Board for approval.

a. If the Medical Executive Committee provides a written objection to a Bylaw adopted pursuant to Section XVII.A.2, without a Medical Executive Committee report, or a Rule, Regulation, Policy and/or amendment adopted by the Medical Staff Section XV.C.1, 2 or 3, within five (5) days of receipt to the Medical Staff, such Bylaw, Rule, Regulation and/or amendment shall not be transmitted to the Board.

(i) Each of Medical Staff and Medical Executive Committee shall appoint three (3) members to a Reconciliation Committee.

(ii) The Reconciliation Committee shall meet and in good faith discuss each parties' concerns, both those of the Medical Staff prompting the Bylaw, Rule, Regulation, Policy and/or amendment, and those of the Medical Executive Committee prompting the objection, and agree on a version of the Bylaw, Rule, Regulation, Policy and/or amendment to transmit to the Board.

(iii) If agreement cannot be reached within five (5) days of the written objection being received, the Bylaw, Rule, Regulation, Policy and/or amendment shall be transmitted to the Board as originally approved by the Medical Staff.

XVII. AMENDMENTS TO THE BYLAWS

XVII.A. AMENDMENT BY ACTIVE STAFF

XVII.A.1. These Bylaws may be amended by those Medical Staff Members entitled to vote.

XVII.A.2. A Bylaws amendment may be discussed at any regular or any special Medical Staff meeting provided that a copy of the proposed amendment(s) as approved by the Medical Executive Committee has been distributed to each Member entitled to vote at least fifteen (15) days in advance of such meeting. If the Medical Executive Committee fails to report on the proposed amendment within ninety (90) days of receipt of a request for a Bylaws amendment, the Medical Staff shall discuss the proposed amendment absent a recommendation of the Medical Executive Committee at the next regular or special Medical Staff meeting, provided that the Bylaws amendment(s) has been distributed to all Members entitled to vote fifteen (15) days in advance of said meeting.

XVII.A.3. Some proposed bylaws amendments are initiated for the purpose of compliance with accreditation standards or regulations. Some amendments are initiated for simple clarification of these bylaws. Some amendments may appear to have no significant controversy for the Medical Staff at large. In these circumstances, the Medical Executive Committee may elect, by unanimous consent of the Medical Executive Committee members present and voting, to bypass the presentation of the proposed bylaws amendments at a Medical Staff meeting as described in Section XVII.A.2 above. The proposed amendment will then be circulated to the Members of the Medical Staff who are entitled to vote as described in section XVII.A.4. If five (5) or more of the Medical Staff Members who are

eligible to vote, object to voting on the amendment without prior discussion at a Medical Staff meeting, voting will be suspended, and the proposed amendment will be presented at the next regular Medical Staff meeting or at a special meeting of the Medical Staff in accordance with Section XVII.A.2 above.

XVII.A.4. Vote.

A proposed bylaws amendment will be voted on by Members of the active Staff entitled to vote as follows: (a) via written ballot hand-delivered, sent by regular mail, emailed, or sent by facsimile to each eligible Active Medical Staff Member following the regular or special Medical Staff meeting in which the proposed amendment was discussed; (b) via written ballot hand-delivered, sent by regular mail, emailed, or sent by facsimile to each eligible Active Medical Staff Member absent discussion at a Medical Staff meeting under those circumstances described in Section XVII.A.3 above; or (c) at the discretion of the Chief of Staff, at the meeting in which the proposed bylaws amendment is discussed as long as (i) a quorum of Members eligible to vote are present and (ii) the intention to vote on a given proposed amendment is indicated in a meeting packet distributed prior to the meeting. If a proposed bylaws amendment is voted upon as provided in subsection (c) above, a Medical Staff Member who is eligible to vote may submit an absentee ballot prior to the meeting.

XVII.A.5. Majority Approval Required.

An amendment shall require a vote of approval by a majority of those active Medical Staff Members voting, provided that at least a quorum (50%) of the active Medical Staff, who are eligible to vote, votes on the amendment.

XVII.A.6. Approval by Board of Trustees.

Amendments approved by a vote of the Medical Staff shall be effective only when approved by the Board of Trustees and the filing of a copy of the amended bylaws with the County Clerk.

XVII.A.7. Provisional amendment for compliance with accreditation standard, law or regulation.

The Medical Executive Committee may, by unanimous consent of the Medical Executive Committee members present and voting at a regular or special meeting or the Medical Executive Committee, introduce, discuss, vote on and provisionally approve new Bylaws

and/or amendments initiated only for the purpose of compliance with an accreditation standard, law or regulation, and transmit such provisionally approved Bylaw(s) and/or amendments to the Board for its provisional approval, without prior approval of the Medical Staff of the Bylaws and/or amendments as set out in Section XVII.A.4. Such provisional approval of a Bylaw or amendment shall be effective only until the next special or regularly scheduled meeting of the Medical Staff.

XVII.B. AMENDMENT BY THE BOARD OF TRUSTEES

These Bylaws may be amended by the Board of Trustees at any regular or special meeting of the Board of Trustees. A copy of any proposed amendment(s) to these Bylaws shall be distributed to each member of the Medical Executive Committee at least thirty (30) days in advance of the meeting at which the Board of Trustees proposes to take final action thereon. If a majority of the members of the Medical Executive Committee are in disagreement with the proposed amendment(s), the matter shall be referred to the Joint Conference Committee for further study and recommendation before final action is taken by the Board of Trustees. Any amendment(s) to these Bylaws adopted by the Board of Trustees shall become effective when notice is given to the Medical Staff and the filing of a copy of the amended bylaws with the County Clerk.

XVII.C. UNILATERAL AMENDMENT

Neither the Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Bylaws.

XVII.D. ADMINISTRATIVE

Copies of any approved amendments shall be appended to a master copy of these Bylaws, until such time that they can be inserted into the text of a revised set of Bylaws. The Medical Staff Office shall maintain the master copy of the Bylaws, with any attached amendment(s). Copies of the approved amendment(s), or the revised Bylaws, shall be sent to each Member of the Medical Staff.

XVII.E. REVIEW AND AMENDMENT

These bylaws may be amended as necessary according to the procedures above. That notwithstanding, the bylaws in their entirety will be reviewed at a minimum every three (3) years with a focus on the following:

XVII.E.1. Compliance with state, federal and other applicable standards and regulations;

XVII.E.2. Consistency with Medical Staff rules/regulations and policies;

XVII.E.3. Consistency with hospital district bylaws;

XVII. ADOPTION OF ST. JOHN'S HOSPITAL BYLAWS OF THE MEDICAL STAFF

XVII.A.1. These Bylaws, together with the appended rules and regulations, shall be adopted by a vote of approval by the majority of those active Medical Staff Members voting, provided that at least a quorum (50%) of the active Medical Staff, who are eligible to vote, votes on the adoption, pursuant to Article XVI, and shall replace any previous Bylaws, rules and regulations, and shall become effective when approved by the Board of Trustees of the Hospital. Such approval shall not be unreasonably withheld.

XVII.A.2. These Bylaws have been revised and adopted by the active Medical Staff of the Hospital and approved by the Board of Trustees.

XVII.A.3. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

XVII.A.4. Amendments to the bylaws shall only become effective after approval of the Board of Trustees and the filing of a copy of the amended bylaws with the County Clerk.

ADOPTED by the Medical Staff on this 24 day of July, 2020

By:________________________
Signature, Chief of Staff

APPROVED by the Board of Trustees on this 23 day of July, 2020

By________________________
Signature, President, Board of Trustees