

MEDICAL STAFF BYLAWS

of

AITKIN COMMUNITY HOSPITAL, INC.

Doing Business As

RIVERWOOD HEALTHCARE CENTER

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DEFINITIONS

1. The term “Hospital” or “Facility” means Aitkin Community Hospital, Inc., a Minnesota non-profit corporation, which owns and operates facilities that provide acute care, extended care and related services under the name: Riverwood Healthcare Center.
2. The term “Physician” means a doctor of medicine or a doctor of osteopathic medicine who is licensed in Minnesota.
3. The term Licensed Independent Practitioner (LIP) means a medical professional who has a license to practice his or her profession in Minnesota and who is otherwise eligible for appointment to the Medical Staff.
4. The term “Organized Medical Staff” means all eligible Practitioners granted a Medical Staff appointment according to the provisions of the Medical Staff Bylaws of the Hospital.
5. The term “Member” or “Members of the Medical Staff” means Practitioners appointed to the Medical Staff.
6. The term “Allied Practitioner” means an individual who provides or affects patient care, but is otherwise ineligible for Medical Staff membership.
7. The term “Governing Body” means the Board of Directors of Aitkin Community Hospital, Inc.
8. The term “CEO” means the individual appointed by the Governing Body to act in its behalf in the overall management of the Hospital.
9. The term “Administration” means the management organization, headed by the CEO, which is charged by the Governing Body with the responsibility for the overall day-to-day operation of the Hospital.
10. The term “Clinical Privileges” means the authorization by the Governing Body to a Practitioner for the provision of certain health care services within well defined limits according to the provisions of the Medical Staff Bylaws of the Hospital.
11. The term “Medical Executive Committee” means a committee comprised of Members of the Medical Staff as voting members, which will organize and conduct the activities of the Medical Staff according to the terms of these Medical Staff Bylaws.
12. The term “Emergency” means a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.
13. The term “Chief of Staff” means the member of the Active Medical Staff elected or confirmed to serve as chief administrative officer of the Medical Staff.

14. The term “Applicant” means or refers to a Practitioner who has formally applied to be a member of the Medical Staff.
15. The term “Medical Staff Year” means the period of time from the first day of October through the last day of September.
16. The term “Good Standing” means the Practitioner in question, at the time the issue is raised, has privileges which are in full force and effect, has met applicable Medical Staff attendance requirements during the prior twelve (12) months and has not experienced a suspension or curtailment of clinical or admitting privileges at the Hospital during the prior twelve (12) months, other than for medical record completion delinquency.
17. The term “Specified Cause” means abuse of office, conflict of interest, failure to appropriately discharge the responsibilities of the office, legal indictment or conviction, moral turpitude or any action or omission that is potentially detrimental to the reputation or proper governance of the Hospital or the Medical Staff.
18. The term “Chief Medical Officer” or “CMO” means the member of the Active or Administrative Medical Staff employed to provide substantial input into the direction and operations of the Hospital and clinics and its relationship with the Medical Staff.

ARTICLE 1. NAME

The name of this Hospital organization is the Medical Staff of Aitkin Community Hospital, Inc., which does business as Riverwood Healthcare Center.

ARTICLE 2. PURPOSE AND AUTHORITY

2.1 PURPOSES OF THE MEDICAL STAFF

2.1-1 Enumerated Purposes

- (a) To organize the activities of Practitioners in the Hospital in order that they may carry out, in conformity with these bylaws, the functions delegated to the Medical Staff by the Governing Body.
- (b) To strive to maintain and enhance the care delivered and the professional performance of all Members of the Medical Staff through an ongoing review and evaluation of the clinical performance of each Member of the Medical Staff and all practitioners with privileges in the Hospital.
- (c) To provide a means whereby issues concerning the Medical Staff and the Hospital may be directly discussed by the Medical Staff with the Governing Body and the Administration, with the understanding that the Medical Staff is subject to the ultimate authority of the Governing Body and that the cooperative efforts of the Medical Staff, the CEO and the Governing Body are necessary to fulfill the purposes of the Hospital.
- (d) To report and be accountable to the Governing Body for the quality and appropriateness of the professional performance and ethical conduct of Practitioners.

2.2 AUTHORITY OF THE MEDICAL STAFF

Subject to the authority and approval of the Governing Body, the Medical Staff will have and exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and under the corporate bylaws of the Hospital including, without limitation, the authority to formulate and recommend Medical Staff policies, professional education requirements, clinical coverage requirements (including Emergency Room and on call coverage), teaching responsibilities, committee assignments, criteria for the granting of Medical Staff appointment and Clinical Privileges, admitting privileges, attendance requirements, office location, residence and response time requirements and use outside consultants when performing peer review activities. Notwithstanding the foregoing, the Governing Body retains the authority to suspend, terminate or reverse any action of the Medical Staff that are inconsistent with the Medical Staff Bylaws, the Hospital Bylaws or both. These Medical Staff Bylaws do not constitute a contract between the Hospital and the individual members of the Medical Staff or the Medical Staff as a whole.

ARTICLE 3. MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Except as otherwise provided herein, no Practitioner will admit patients to, or care for patients at, the Hospital unless he or she is a Member of the Medical Staff and has been granted Clinical Privileges in accordance with the procedures set forth in these bylaws. Appointment to the Medical Staff will confer only such Clinical Privileges and prerogatives as have been granted in accordance with these bylaws.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 General Qualifications

Only Practitioners who:

- (a) Document or provide evidence, from primary sources whenever feasible, of (1) current licensure, (2) adequate experience, education and relevant training, (3) current professional competence, (4) judgment and (5) ability to perform the Clinical Privileges requested, including adequate physical and mental health status, in relation to the Clinical Privileges requested, which demonstrate to the satisfaction of the Hospital that they are professionally competent and that patients treated by them can reasonably expect quality medical care;
- (b) Are willing to properly discharge the responsibilities established by the Hospital;
- (c) Satisfy any applicable office or residence location requirements;
- (d) Demonstrate willingness and ability to work cooperatively with other Practitioners in a professional manner; and
- (e) Provide evidence of satisfactory compliance with professional liability insurance requirements will be deemed to possess the basic qualifications for membership in the Medical Staff, except for the Honorary Staff category in which case these criteria will only apply as deemed individually applicable by the Hospital.

3.2-2 Particular Eligible Licenses

- (a) Physicians. A Physician Applicant for membership on the Medical Staff, except in the Honorary Staff category, must hold a degree of doctor of medicine or doctor of osteopathic medicine issued by a medical or osteopathic school, approved at the time of the issuance of such degree by the State of Minnesota, or must have a diploma or a license approved by the

State of Minnesota which confers a full right to practice all branches of medicine or surgery in a foreign country, or must have graduated from an unapproved medical school not located in the United States or Canada, but successfully completed the medical education evaluation program authorized under Minnesota state law, and must also hold a valid and unsuspended license to practice medicine and surgery or osteopathic medicine and surgery issued by the State of Minnesota. All Physician Applicants must be either Board certified or Board eligible. Physicians who are not Board certified at the time of initial appointment to the Medical Staff must become Board certified within two years of their initial appointment. Failure to obtain Board certification within such period shall result in a loss of Clinical Privileges and the Physician will not be entitled to procedural rights under Article 11. Notwithstanding the foregoing, the MEC may review any such failure and grant an extension in the case of a Physician that demonstrates the need for such an extension based on his or her physical or mental disability or other reasonable grounds. Any such exception shall be reviewed annually by the MEC.

- (b) Dentists. Dentists and oral surgeons applying for membership on the Medical Staff, except in the Honorary Staff category, must hold a doctor of dental surgery or equivalent degree issued by a dental school approved at the time of the issuance of such degree by the State of Minnesota and must also hold a valid and unsuspended certificate to practice dentistry and/or oral surgery issued by the State of Minnesota.
- (c) Podiatrists. A podiatrist Applicant for membership on the Medical Staff, except in the Honorary Staff category, must hold a degree of Doctor of Podiatric Medicine conferred by a college of podiatry approved at the time of issuance of such degree by the State of Minnesota and must also hold a valid and unsuspended certificate to practice podiatry issued by the State of Minnesota.

3.2-3 Expectations

All practitioners are expected to:

- (a) Provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
- (b) Demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.
- (c) Be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

- (d) Demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
- (e) Demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.
- (f) Demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

3.3 EFFECT OF OTHER AFFILIATIONS

No person will be entitled to membership on the Medical Staff or Clinical Privileges merely because he or she holds a certain degree, is licensed to practice in this or in any other State, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at the Hospital or at another health care facility (irrespective of whether it is affiliated with the Hospital), is affiliated with a group of Practitioners, some of whom have Medical Staff membership or Clinical Privileges at the Hospital, or holds a contract with the Hospital or any other provider or payor. Allied Practitioners are not members of the Medical Staff and do not have procedural rights under these Medical Staff Bylaws, although they are subject to the privileging and credentialing process set forth under Article 5.

3.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular Clinical Privileges will be denied on the basis of race, color, creed, religion, ancestry, sex, national origin, disability, age, sexual orientation, marital status, veteran status, political affiliation, status with regard to public assistance, genetic information, any other legally protected status or class, or any criteria unrelated to the delivery of quality patient care in the Hospital, professional qualifications, the Hospital's purposes, needs and capabilities, or community need.

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the Honorary Staff, the ongoing responsibilities of each member of the Medical Staff include:

- (a) Providing patients in a reasonably efficient manner with continuous quality care that meets generally recognized professional standards and participating in the education of patients and families.

- (b) Managing and coordinating the care, treatment and services of patients, including coordination among practitioners where appropriate and Physician evaluation of the quality and appropriateness of the diagnosis and treatment furnished by Allied Practitioners.
- (c) Obtaining the patient's informed consent to treatment consistent with the procedures set forth in the Medical Staff Policies.
- (d) Performing a patient's medical history and physical examination in accordance with the following requirements and any corresponding details set forth in the Medical Staff Policies:
 - (i) not more than thirty (30) days prior to and by the end of the calendar day following admission of the patient to the Hospital;
 - (ii) a medical history and physical examination will be completed prior to surgery or an outpatient procedure requiring anesthesia services; and
 - (iii) any history and physical examination conducted by a medical student, Allied Practitioner, intern or resident shall be signed by the attending Physician before the time stated for the procedure.
- (e) Abiding by and enforcing the Medical Staff Bylaws, Medical Staff Rules and Regulations, and the Hospital bylaws and policies.
- (f) Completing such reasonable responsibilities, assignments and rotations imposed upon the Member by virtue of Medical Staff membership, including committee assignments, proctoring of Practitioners, attendance requirements and accreditation requirements.
- (g) Participating on, with or in Hospital or multi-disciplinary committees, teams or programs dealing with the overall medical environment and performance improvement activities at the Hospital including, without limitation, such functions as medical records, performance improvement, utilization review, practice guidelines, blood usage/blood component review, nursing services, drug usage and formularies, infection control, radiation safety, risk management, operative and invasive procedure review, safety and patient care policies.
- (h) Preparing and completing in a timely and legible fashion all medical records, including discharge summaries, for the patients to whom the Member provides care in the Hospital.
- (i) Providing indigent care according to Hospital policy.
- (j) Making appropriate arrangements for coverage of his or her patients and coordinating care with other Practitioners and Hospital personnel as is relevant to the care of each patient.

- (k) Participating in continuing education programs as determined and documented by the Hospital, which programs will relate, at least in part, to the type and nature of care offered by the Hospital and the findings of performance improvement activities.
- (l) Participating in such emergency service coverage, consultation panels or on call coverage as may be determined by the Hospital or as otherwise covered in a written agreement between the Hospital and Medical Staff Member.
- (m) Maintaining personal medical malpractice insurance coverage as determined by the Hospital.
- (n) Informing the Medical Staff, in a timely manner, of any changes made, whether voluntary or involuntary, or formal action initiated that could result in a change of license, DEA registration, participation in any program or plan for the reimbursement of services, professional liability insurance coverage, membership or employment status or Clinical Privileges at other health care institutions or affiliations, the initiation, status or disposition of malpractice claims and changes affecting the ability to competently and safely exercise the Clinical Privileges granted hereunder.
- (o) Working with other individuals and organizations in a cooperative, professional and civil manner and refraining from any activity that is disruptive of Hospital operations.
- (p) Adhering to the ethical standards generally applicable to his or her licensure.
- (q) Performing a sufficient number of procedures, managing a sufficient number of cases and having sufficient patient care contact within the Practitioner's practice, as determined by the Medical Executive Committee in consultation with the Credentials Committee, to permit the Hospital to assess the Practitioner's current clinical competence for any Clinical Privileges, whether being requested or already granted.
- (r) Cooperating in any relevant or required review of a Practitioner's (including one's own) credentials, qualifications or compliance with these bylaws and refraining from directly or indirectly interfering, obstructing or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to perform or participate in assigned responsibilities or otherwise.
- (s) Cooperating with and participating in the Hospital's malpractice prevention program, performance improvement program and peer review activities, whether related to oneself or others.
- (t) Seeking consultation, in accordance with generally accepted standards of patient care, upon a medical determination: a diagnosis is obscure, there is doubt as to the best therapeutic measures, the patient is not a good medical or surgical risk, in unusually complicated situations where the specific skills of other Practitioners may

be needed, at the request of the patient or his or her family when there are severe psychiatric symptoms, or when requested by the Chief of Staff.

- (u) Discharging such other Medical Staff obligations as may be lawfully established from time to time by the Medical Staff, the Medical Executive Committee or the Governing Body.

ARTICLE 4. CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

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

4.2 ACTIVE MEDICAL STAFF

4.2-1 Qualifications

The Active Staff will consist of Practitioners who:

- (a) Meet the general qualifications for membership set forth in these Medical Staff Bylaws and specifically in Article 3.
- (b) Have offices or residences which, in the opinion of the Hospital, are located closely enough to the Hospital to provide adequate continuity of care.
- (c) Regularly care for patients in this Hospital and are regularly involved in Medical Staff functions (social functions excluded), as determined by the Hospital.
- (d) Except for good cause shown, have satisfactorily completed their designated provisional period.

4.2-2 Prerogatives

Except as otherwise provided, the prerogatives of an Active Medical Staff Member will be to:

- (a) Admit patients and exercise such Clinical Privileges as are granted pursuant to Article 6.
- (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.
- (c) Hold Medical 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.

4.2-3 Transfer of Active Staff Member

After two consecutive years in which a Member of the Active Medical Staff fails to regularly care for patients in this Hospital, satisfy attendance requirements or be regularly involved in Medical Staff functions as determined in these bylaws, by the Medical Staff Rules and Regulations, or by the Hospital, that Member will, upon such a finding by the Medical Executive Committee and the approval of the Governing Body, automatically be transferred to the appropriate category, if any, for which the Member is qualified without any procedural rights under Article 11.

4.3 THE COURTESY MEDICAL STAFF

4.3-1 Qualifications

The Courtesy Staff will consist of members who:

- (a) Meet the general qualifications set forth in Subsections (a) and (b) of Section 4.2-1.
- (b) Do not regularly care for or are not regularly involved in Medical Staff functions and do not admit patients, as determined by the Medical Staff.
- (c) Are members in good standing of the Active Medical Staff of another Minnesota licensed hospital, although exceptions to this requirement may be recommended by the Medical Executive Committee for good cause but must be approved by the Governing Body.
- (d) Except for good cause shown, have satisfactorily completed their designated provisional period.

4.3-2 Prerogatives

Except as otherwise provided, the Courtesy Medical Staff Member will be entitled to:

- (a) Exercise such Clinical Privileges as are granted pursuant to Article 6.
- (b) Attend meetings of the Medical Staff, committee meetings and educational programs, but will have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Courtesy Staff Members will not be eligible to hold office in the Medical Staff or to vote on Medical Staff matters.

4.4 THE CONSULTING MEDICAL STAFF

4.4-1 Qualifications

Any Member of the Medical Staff in good standing may consult in his or her area of expertise; however, the Consulting Medical Staff will consist of such Practitioners who:

- (a) Are not otherwise Members of the Medical Staff and meet the general qualifications set forth in Article 3, except that this requirement will not preclude an out-of-state Practitioner from appointment as may be permitted by law, if that Practitioner is otherwise deemed qualified by the Medical Executive Committee with the approval of the Governing Body.
- (b) Possess adequate clinical and professional expertise.
- (c) Do not admit patients.
- (d) Are willing and able to come to the Hospital on schedule or promptly respond when called to render clinical services within their area of competence.
- (e) Are Members of the Active Medical Staff of another hospital licensed by the State of Minnesota or another state, although exceptions to this requirement may be made by the Medical Executive Committee with the approval of the Governing Body for a good cause.
- (f) Except for good cause shown, have satisfactorily completed their designated provisional period.

4.4-2 Prerogatives

The Consulting Medical Staff member will be entitled to:

- (a) Exercise such Clinical Privileges as are granted pursuant to Article 6, but are not entitled to admit patients to the Hospital and therefore the Admitting Staff Member shall retain responsibility for the patient's care.
- (b) Attend meetings of the Medical Staff, committee meetings and educational programs, but will have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
- (c) Consulting Medical Staff Members will not be eligible to hold office in the Medical Staff, but may serve upon committees.

4.5 HONORARY STAFF

4.5-1 Qualifications

The Honorary Staff will consist of Practitioners who do not actively practice at the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital, and who continue to exemplify high standards of professional conduct.

4.5-2 Prerogatives

Honorary Staff members are not entitled to admit patients to the Hospital or to exercise Clinical Privileges in the Hospital, or to vote or hold office in the Medical Staff, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend Medical Staff meetings, committee meetings and educational programs.

4.6 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 Medical Staff Bylaws and by the Medical Staff Rules and Regulations. Subject to approval by the Governing Body, Honorary Staff membership may be revoked by a two-thirds vote of the Medical Executive Committee or a majority vote of the Medical Staff, without any procedural rights under Article 11.

4.7 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a Member, the Medical Executive Committee may recommend a change in the Medical Staff category of a Member consistent with the requirements of these bylaws to the Governing Body.

4.8 PROVISIONAL STATUS

4.8-1 Qualifications

At the time of initial appointment and for a period of time thereafter as set forth in Section 4.8-4, Members of the Medical Staff are provisional provided they meet the general Medical Staff membership qualifications set forth in Articles 3 and 4.

4.8-2 Prerogatives

The provisional Member will be entitled to:

- (a) Exercise such Clinical Privileges as are granted pursuant to Article 6.

- (b) Attend meetings of the Medical Staff, committee meetings and educational programs, but will have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Provisional members will not be eligible to hold office in the Medical Staff, but may serve upon committees.

4.8-3 Observation of Provisional Staff Member

Each provisional Member of the Medical Staff will undergo a focused professional practice evaluation that includes a period of observation by designated Hospital staff appointed by the Chief of Staff. The observation will be to evaluate the Member's (1) proficiency in the exercise of Clinical Privileges initially granted, (2) satisfactory discharge of the basic responsibilities of Medical Staff membership and (3) over-all eligibility for continued Medical Staff membership and advancement within Medical Staff categories. Subject to Section 4.8-4 and the approval of the Governing Body, observation of provisional Members will follow whatever frequency and format is deemed appropriate by the Credentials Committee in order to adequately evaluate the provisional Member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records will be maintained. The results of the observation will be communicated by the Chief of Staff to the Credentials Committee.

4.8-4 Term of Provisional Status

A member will be provisional for a period of not less than twelve (12) months ("provisional period"), and that status may be extended by the Medical Executive Committee for two additional periods of six months upon a determination of good cause, which determination will not be subject to procedural rights under Article 11. A provisional member will be reviewed at the end of the twelve month provisional period and any six month extension. A provisional member who fails to perform enough procedures at the Hospital to permit an evaluation of his or her clinical competence will not be advanced to the appropriate category or granted Clinical Privileges and will not be entitled to procedural rights under Article 11.

4.8-5 Action at Conclusion of Provisional Status

At the end of each provisional period, the Medical Executive Committee will make a report and recommendation to the Governing Board on the Member's ability to exercise the Clinical Privileges initially granted.

- (a) If the recommendation of the Medical Executive Committee is favorable, and with the approval of the Governing Body, the Member will automatically be placed in the Active, Courtesy or Consulting Medical Staff category, as appropriate.

- (b) If the Medical Executive Committee recommends a modification or termination of Clinical Privileges, and the Governing Body concurs, then the decision of the Governing Body is final subject to the procedural rights set forth in Article 11. If the Governing Body does not concur with the Medical Executive Committee's recommendation, then the matter will be referred to an ad hoc joint conference committee for review and, recommendation to the Governing Body within 15 days. The ad hoc joint conference committee will be appointed by the Chairman of the Governing Body, in consultation with the Chief of Staff, and will consist of two members of the Governing Body and two Active Staff Members of the Medical Staff. Upon receipt of the recommendation of the ad hoc joint conference committee, the Governing body will, within thirty (30) days of the receipt of same, make a decision in writing explaining its rationale. Its decision will be final. Notice of this decision will be given as set forth in Section 5.5-8.

Unless effected under Section 10.2 hereof, a modification or termination of Clinical Privileges will not take effect until any procedural rights under Article 11, and requested by the Member, have been completed.

ARTICLE 5. MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES

5.1 GENERAL

Except as otherwise specified herein, no Practitioner (including Practitioners engaged by the Hospital in administratively responsible positions) will exercise Clinical Privileges in the Hospital unless and until he or she applies for and receives appointment to the Medical Staff or is granted temporary or disaster privileges as set forth in these bylaws. By applying to the Medical Staff for appointment or reappointment (or, in the case of members of the Honorary Staff, by accepting an appointment to that category), the Applicant acknowledges responsibility to first review these bylaws, and agrees that throughout any period of membership he or she will comply with the responsibilities of Medical Staff membership and with the bylaws, rules and regulations and policies of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff will confer on the appointee only such Clinical Privileges as have been granted in accordance with these bylaws. Said Clinical Privileges must be Hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this State and consistent with any restrictions thereon, and will be subject to the rules and regulations of the Medical Staff. Requests for Clinical Privileges shall be evaluated on the basis of the information included in the Application Form as required in Section 5.5-1 and any additional information required by Section 5.6. Requests shall also be evaluated on the basis of the Member's clinical performance, demonstrated current professional competence, documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. The Hospital is under no obligation to grant any requested Clinical Privileges if it does not have the facilities, financial resources or clinical staff to support them or if the service is otherwise provided. The declination of such requests may be done in accordance with Hospital policy and does not entitle the applicant

to procedural rights under Article 11. In the classification or categorization of clinical privileges, the Medical Staff will use a system where the scope of each level of privileges is well defined and the standards to be met are stated clearly for each category.

5.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, modification of Clinical Privileges or transfer, the Applicant will have the burden of timely producing information for an adequate evaluation of the Applicant's qualifications and suitability for the Clinical Privileges and the Medical Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying reasonable requests for information. The Applicant's failure to sustain this burden in a timely fashion will be grounds for denial of the application, which will be considered as voluntarily withdrawn, without any procedural rights under Article 11. This burden may include submission to a medical or psychiatric examination at the Applicant's expense, if deemed appropriate for the Clinical Privileges requested. The Medical Executive Committee will select the examining Physician.

5.3 APPOINTMENT AUTHORITY

Appointments, denials, suspensions and revocations of appointments to the Medical Staff will be made as set forth in these bylaws, but only after there has been a recommendation from the Medical Staff, provided the Governing Body may act directly if the Medical Staff refuses to act on an application or unreasonably delays (failure to make a recommendation to the Governing Body within one hundred twenty (120) days of the receipt of a completed application) acting on an application.

5.4 DURATION OF APPOINTMENT, REAPPOINTMENT AND PRIVILEGES

Except as otherwise provided in these bylaws, initial appointments and reappointments to the Medical Staff will be for a period for 2 years. All privileges are granted for a period not to exceed two (2) years.

5.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

5.5-1 Application Form

Application forms (which may include a pre-application) will be developed by the Medical Executive Committee and approved by the Governing Body. The form will require detailed information which will include, but not be limited to, information concerning:

- (a) The Applicant's qualifications, including, but not limited to, relevant professional training and clinical experience, judgment, current licensure, Board certification or eligibility if applicable, professional liability insurance, current DEA registration, verbal and written English language proficiency, a valid government-issued photo identification card, and

documented continuing medical education information related to the Clinical Privileges requested by the Applicant.

- (b) Peer references:
 - (i) In the case of initial appointments, a minimum of three peer references familiar with the Applicant's professional competence (preferably one reference on professional competence should be from someone of the same specialty or training) and character during the prior five years, who are not business associates or family members of the Applicant.
 - (ii) In the case of reappointments, one or more peer references familiar with the Applicant's professional competence (preferable should be from someone of the same specialty or training) and character during the prior five years, who are not business associates or family members of the Applicant.
- (c) Requests for membership categories and Clinical Privileges.
- (d) Previous, and currently pending, professional disciplinary actions, or licensure or registration (state, district, DEA) limitations, irrespective of reinstatement or whether they were voluntary or involuntary.
- (e) Voluntary or involuntary termination of medical staff membership, voluntary or involuntary revocation, suspension or restriction of professional license or DEA registration, voluntary or involuntary limitation, suspension, reduction, loss or non-renewal of Clinical Privileges at another hospital or health care entity, irrespective of reinstatement or withdrawal of an application for Medical Staff membership prior to final action by the hospital, together with a written explanation for such termination or withdrawal, which includes whatever relevant third party information is available to the Applicant.
- (f) Medical Staff membership or Clinical Privileges at any healthcare facility or program which are currently the subject of an investigation or corrective or disciplinary action and the reasons for same.
- (g) Any current membership or Clinical Privileges or any pending application for Medical Staff membership or Clinical Privileges at another healthcare facility or program.
- (h) Physical and mental health status as they relate to the Clinical Privileges requested, including a statement that no health problems exist that could affect his or her ability to perform the Clinical Privileges requested.

- (i) Final judgments or settlements, together with pending actions, against the Applicant in professional liability actions and proof of current professional liability insurance in such amounts and types as are required by the Hospital.
- (j) Reports to the National Practitioner Data Bank involving the Applicant.
- (k) Any formal sanctions by Medicare or Medicaid.
- (l) Any criminal convictions, involving any felony and any misdemeanor, provided the misdemeanor involved professional activity or a crime of moral turpitude.
- (m) Sequential history of medical career, accounting for every year since graduation from professional school.
- (n) Any allegations of civil or criminal fraud pending against the Applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participating in any health insurance program, including Medicare or Medicaid.
- (o) Whatever additional reasonable information the Hospital or the Medical Staff deems relevant.
- (p) Certification in Advanced Cardiac Life Support (ACLS) is required upon initial appointment and reappointment for all Members who provide call, admissions, rounding, or care in outlying clinics and Members who hold privileges for moderate sedation. Exceptions: Orthopedics and Oncology
- (q) Either Advanced Trauma Life Support (ATLS), Comprehensive Advanced Life Support (CALS) or a comparable certification is required in addition to ACLS upon initial appointment and reappointment for all Members who provide coverage in the Emergency Department and all Mid-Levels (Nurse Practitioners and Physician Assistants) who provide coverage in the clinics. For all Mid-Levels providing coverage in the hospital, a six month grace period may be granted to obtain ATLS or CALS following initial appointment and a six month grace period may be granted for renewing ATLS or CALS certifications. The Chief of Staff will review and approve comparable certification in advance of appointment.

Each application for initial appointment to the Medical Staff will be in writing, submitted to the CEO on the prescribed forms with all provisions completed (or accompanied by acceptable explanations of why answers are unavailable), include any required application fee, a valid government-issued photo identification card and must be signed by the Applicant (“completed application”). When an Applicant requests an application form, he or she will be given a copy of these bylaws, the Medical Staff Rules and Regulations and summaries of other applicable policies related to clinical practice in the Hospital, if any.

5.5-2 Effect of Application

In addition to the matters set forth in this Article 5, by applying for appointment to the Medical Staff each Applicant:

- (a) Signifies his or her willingness to appear for interviews in regard to the application.
- (b) Authorizes consultation with others who have been associated with him or her and who may have information bearing on his or her competence, qualifications and performance and authorizes such individuals and organizations to candidly provide all such information.
- (c) Consents to inspection and copying of records and documents that may be material to an evaluation of his or her qualifications (licensure, certification, specific training, experience, and current competence) and ability to carry out Clinical Privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying.
- (d) Releases from any liability, to the fullest extent permitted by law, all individuals or organizations for their acts performed in good faith without malice in connection with investigating and evaluating the Applicant and will provide individual releases, if requested by the Medical Staff or the Hospital.
- (e) Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information in good faith without malice regarding the Applicant, including otherwise confidential information and will provide individual releases, if requested by the Medical Staff or the Hospital.
- (f) Consents to the disclosure to other hospitals, medical associations, managed care organizations, payors and licensing boards, and to other similar organizations as required by law, any information regarding his or her professional standing or competence that the Hospital, Medical Staff or any individual may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law.
- (g) Pledges to provide for continuous quality care in a reasonably efficient manner for his or her patients.
- (h) Agrees to exhaust all remedies available under these Medical Staff Bylaws before commencing a legal action against the Medical Staff or any committee or Member of the Medical Staff, or against the Hospital for any investigation or action taken in accordance with the provisions of these

Medical Staff Bylaws, the Medical Staff policies or the corporate bylaws and policies of the Hospital.

- (i) Agrees to immediately inform the Hospital of any changes or developments affecting or changing the information provided in or with his or her application for initial appointment, reappointment, or temporary privileges.
- (j) Acknowledges that a failure by the Applicant to timely complete an application form, the withholding of requested information, or the providing of false or misleading information will, by itself, constitute a basis for the denial or revocation of Medical Staff membership and/or Clinical Privileges and that such a denial or revocation will not constitute an adverse action entitling the Applicant to procedural rights under Article 11.
- (k) Accept the basic responsibilities of Medical Staff Membership as set forth in these Medical Staff Bylaws.
- (l) Agrees to acknowledge in writing that his or her activities as a Medical Staff Member are governed by the bylaws, rules and regulations and policies of the Hospital and the Medical Staff.

5.5-3 Verification of Information

The Applicant will deliver a completed application to the Medical Staff office within ninety (90) days of the date the application is mailed to the Applicant. A failure to do so, without good cause, will terminate the application without any procedural rights under Article 11 and the Applicant may not reapply for one year. The CEO, or his or her designee, will be notified of the application. The Credentials Committee, or an outside credentialing service, will expeditiously seek to collect or verify in writing the identity of the Applicant and the references, licensure status, and other evidence submitted in support of the application. The Applicant will be notified of any problems in obtaining the information required, and it will be the Applicant's obligation to obtain the required information in a timely manner and a failure to do so will be considered a voluntary withdrawal of the application, which is not subject to the procedural rights otherwise available under Article 11. When collection and verification is accomplished, all such information will be transmitted to the Credentials Committee. As part of this process, an inquiry will be made to the National Practitioner Data Bank.

5.5-4 Credentials Committee Action

The Credentials Committee will review the application, evaluate and verify as needed the supporting documentation, and other relevant information. The Credentials Committee will transmit to the Medical Executive Committee its recommendations as to appointment and, if appointment is recommended, as to Medical Staff category, Clinical Privileges to be granted, and any special conditions

to be attached to the appointment through the Credentials Committee meeting minutes..

5.5-5 Medical Executive Committee Action

At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee will consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation.

- (a) Favorable Recommendation. When the recommendation of the Medical Executive Committee is favorable to the Applicant, it will be promptly forwarded, together with supporting documentation, to the Governing Body.
- (b) Adverse Recommendation. When the recommendation of the Medical Executive Committee is adverse to the Applicant, the Applicant will promptly be informed by written notice which includes the basis for the adverse recommendation. This notice will be the first notice required under Article 11. The Applicant will then be entitled to procedural rights under Article 11.

Notwithstanding anything in these bylaws to the contrary, the Chief of Staff may, in certain circumstances specifically set forth in Medical Staff policy approved by the Governing Body, act on behalf of the Medical Executive Committee under this Subsection 5.5-5.

5.5-6 Governing Body Action on the Application

The Governing Body may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral. The following procedures will apply with respect to action on application:

- (a) If the Governing Body concurs with the recommendation of the Medical Executive Committee, the decision of the Governing Body will be final.
- (b) If the Governing Body does not concur with the recommendation of the Medical Executive Committee, then the matter will be referred to an ad hoc joint conference committee constituted as described in Section 4.8-5(b) above. Upon receipt, the ad hoc joint conference committee will, within fifteen (15) days, review the application and provide the Governing Body with its written recommendation. Within thirty (30) days of its receipt of the recommendation of the joint conference committee, the Governing Body will make a decision in writing explaining its rationale. If the decision of the Governing Body is adverse to the Applicant, the Applicant will then be

entitled to procedural rights under Article 11, if they were not previously exercised in regards to this adverse action.

Notwithstanding anything in those bylaws to the contrary, the CEO may, in certain circumstances specifically set forth in Medical Staff policy approved by the Governing Body, and in accordance with the Hospital's bylaws, act on behalf of the Governing Body under this Subsection 5.5-6.

5.5-7 Notice of Final Decision

- (a) Notice of the final decision will be promptly given to the Chief of Staff, the Medical Executive Committee and the Credentials Committee, the Applicant, and the CEO. External persons or entities will also be notified as required by law.
- (b) A decision and notice to appoint or reappoint will include, if applicable: (1) the Medical Staff category to which the Applicant is appointed; (2) the Clinical Privileges granted; and (3) any special conditions attached to the appointment.

5.5-8 Reapplication After Adverse Appointment Decision

An Applicant who has received a final adverse decision regarding appointment will not be eligible to reapply to the Medical Staff for a period of one year from the date of the final decision. Any such reapplication will be processed as an initial application, and the Applicant will submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

5.5-9 Timely Processing of Applications

Applications for Medical Staff appointment will be considered in a timely manner by all persons and committees required by these bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide only a guideline for routine processing of applications:

- (a) Evaluation, review, and verification of application and all supporting documents under Section 5.5-3 within forty-five (45) days from receipt of a completed application by the Medical Staff Office.
- (b) Review and recommendation by Credentials Committee within sixty (60) days after receipt of a completed application from the Medical Staff office.
- (c) Review and recommendation by Medical Executive Committee within thirty (30) days after receipt of the recommendation of the Credentials Committee.

- (d) Final action by the Governing Body within sixty (60) days after receipt of the recommendation of the Medical Staff Executive Committee or conclusion of hearings.

5.5-10 Practitioners and Allied Practitioners Providing Professional Services by Contract

All physicians are subject to the requirements of Medical Staff, as provided under this Article and Article 4 above. A physician with whom the Hospital contracts to provide services, which involve privileges, must be a Member of the Medical Staff, achieving his or her status by the procedures described in these bylaws. The appropriate medical training, certification and other credential of each practitioner or Allied Practitioner necessary to provide services shall be verified by the contractor. The contractor shall ensure that each practitioner or Allied Practitioner who provides service to the Hospital:

- (a) Is and shall remain duly licensed (if applicable and qualified and in good standing to practice medicine in the State of Minnesota);
- (b) Is Board certified/board eligible in their specialty and shall maintain such certification during the term of any contract; and
- (c) Renders services within the scope of the respective privileges as granted.

~~Based on the above assurances, the Hospital may rely on the Contractor's privileging and credentialing activities in lieu of issuing its own privileges.~~

The Hospital may obtain information and data related to the quality of services provided by the contracted practitioners and Allied Practitioners at Hospital as part of its QI program. Any such quality-related information or data shall be treated as privileged and confidential information. The Hospital shall protect such privileged and confidential QI information from disclosure to third parties to the fullest extent provided for all applicable federal and state statutes, regulations and case law.

5.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

5.6-1 Application

- (a) At least one hundred and fifty (150) days prior to the expiration date of the current Medical Staff appointment ("Reapplication Due Date"), a reapplication form developed by the Medical Executive Committee, and approved by the Governing Body, will be mailed or delivered to the Member and an inquiry will be made to the National Practitioner Data Bank. At least one hundred and twenty (120) days prior to the Reapplication Due Date, each Medical Staff Member will submit to the Credentials Committee, through the Medical Staff Office, the completed re-application form for renewal of appointment to the Medical Staff for the coming two years, and

for renewal or modification of Clinical Privileges. If an application for reappointment is not returned within thirty (30) days of the date of mailing or delivery to the Member, written notice by certified mail, return receipt requested, will be promptly sent to the Member advising that such reapplication has not been received and explaining that a failure to submit a fully completed reapplication form which can reasonably be processed and approved by the Reapplication Due Date will be deemed a voluntary resignation from the Medical Staff as described in Subsection 5.6-4 below. The reapplication form will include all information necessary to update and evaluate the qualifications of the Applicant including, but not limited to, the matters set forth in Section 5.5-1, as well as other relevant matters. All provisions of the reapplication form must be completed (or accompanied by acceptable explanations of why answers are unavailable), with all applicable fees paid, if any, and signed by the Applicant (completed application). Upon receipt of the completed application, the information will be processed as set forth in Article 5, commencing at Section 5.5-3.

- (b) A Medical Staff member who seeks a change in Medical Staff status or modification of Clinical Privileges may submit such a request at any time upon a form developed by the Medical Executive Committee, approved by the Governing Body and properly completed, except that such application may not be filed within six (6) months of the time a similar request has been denied. The Credentials Committee, through the Medical Staff Office, will verify the competence of any instruction involved, and if the request is approved by the Governing Body, provide for a provisional or proctoring period in which a focused professional practice evaluation will occur and then evaluate the clinical results of such period. Information regarding the scope of a practitioner's privileges is updated as changes are made.

5.6-2 Effect of Application

The effect of the application for reappointment or modification of Medical Staff status or privileges is the same as that set forth in Section 5.5-2.

5.6-3 Standards and Procedure for Review

When a Medical Staff Member submits the first application for reappointment, and every two years thereafter, or when the Member submits an application for modification of Medical Staff status or Clinical Privileges, the Member will be subject to an in-depth review generally following the procedures set forth in Section 5.5-3 through 5.5-9, which will include an assessment of the Member's Ongoing Professional Practice Evaluation conducted in accordance with the procedures set forth in the Medical Staff Policies.

5.6-4 Lapse of Application

If a Medical Staff Member requesting a modification of Clinical Privileges fails to timely furnish the information necessary to evaluate the request, the application will automatically lapse, and the Applicant will not have procedural rights under Article 11.

5.6-5 Medical Executive Committee Modification of Clinical Privileges

On its own or upon recommendation of the Credentials Committee, the Medical Executive Committee may recommend a change in the Clinical Privileges of a Member. The Medical Executive Committee may also recommend the granting of additional privileges to a current Medical Staff Member, such as is provided for in Section 5.6.1(b), be made subject to monitoring in accordance with procedures similar to those outlined in Section 4.8. Action on such recommendation will follow the procedures set forth in Section 5.5.

5.6-6 Failure to File Reappointment Application

Failure to timely file a completed application for reappointment by the Reapplication Due Date as defined in Section 5.6-1(a) above, will result in the automatic termination of the Member's Medical Staff appointment, Clinical Privileges and admitting privileges and prerogatives at the end of the current Medical Staff appointment. The Member will be immediately notified by certified mail. In the event membership terminates for the reasons set forth herein, the procedural rights set forth in Article 11 will not apply. The former Member will be required to reapply as an initial Applicant.

5.7 LEAVE OF ABSENCE

5.7-1 Leave Status

The Medical Executive Committee may, in its discretion, grant a voluntary leave of absence to a Medical Staff Member in good standing upon the submission of a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed twelve (12) months (except for military leaves) or be less than thirty (30) days (although exceptions may be made for military leaves of absence), the reason for the leave and a description of the activity that will occur during the leave. During the period of the leave, the Member will not exercise Clinical Privileges at the Hospital, and membership rights and responsibilities will be inactive.

5.7-2 Termination of Leave

At least 30 days prior to the termination of the leave of absence, or at any time, the Medical Staff Member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee through the

Medical Staff Office. The Medical Staff Member will submit a summary of relevant activities during the leave, if the Medical Executive Committee or Hospital so requests. If a Member of the Medical Staff is granted a leave of absence due to ill health, before Clinical Privileges can be reactivated, the Member must also submit an acceptable statement, from a Physician, stating that the Member is free from any health impairment which is a potential risk to patients or other persons or which might interfere with the performance of his or her duties. The Medical Executive Committee will make a recommendation concerning the reinstatement of the Member's privileges and prerogatives, and, if the Practitioner's current appointment has expired, the procedure in Sections 5.1 through 5.5-9 will be followed. Reappointment will be applied for two (2) years after reinstatement, if the Member's current appointment expired during the leave of absence.

5.7-3 Failure to Request Reinstatement

Failure, without good cause, to timely request reinstatement will be deemed a voluntary resignation from the Medical Staff and will result in automatic termination of Medical Staff membership, Clinical Privileges, and prerogatives. A Member whose membership is automatically terminated will be entitled to the procedural rights provided in Article 11 for the sole purpose of determining whether the failure to request reinstatement is excusable. A request for Medical Staff membership subsequently received from a Member so terminated will be submitted and processed in the manner specified for applications for initial appointment.

5.8 TEMPORARY MEDICAL STAFF MEMBERSHIP

When an outside consultation is necessary to conduct peer review activities, the Medical Executive Committee may, with the approval of the Governing Body, admit a Practitioner or other individual to the Medical Staff for a limited period of time according and subject to the provisions of Section 4-4. Such membership will be solely for the purpose of conducting peer review in a particular case or situation, and this temporary membership will automatically terminate upon the Member's completion of duties in connection with the peer review matter with no procedural rights under Article 11.

5.9 DENIAL FOR HOSPITAL'S INABILITY TO ACCOMMODATE APPLICANT

A decision by the Governing Body to deny Medical Staff membership or Clinical Privileges for any of the following reasons will not constitute an adverse action and will not entitle the Applicant to procedural rights under Article 11: (i) because of an exclusive hospital-based physician agreement; (ii) because of the Hospital's present inability to provide adequate facilities or support services; or (iii) because of a medical staff development plan adopted by the Board.

5.10 ALLIED PRACTITIONERS EMPLOYED BY THE HOSPITAL

Allied Practitioners employed by the Hospital are subject to the credentialing and privileging process under this Article 5 and agree to acknowledge in writing that his or her activities as such are governed by the bylaws, rules and regulations of the Hospital and the Medical Staff. Such individuals are not eligible for appointment to the Medical Staff, have no right to vote on Medical Staff matters and do not have procedural rights under these Medical Staff Bylaws.

ARTICLE 6. CLINICAL PRIVILEGES FOR SPECIFIC MEMBERS AND IN SPECIAL CIRCUMSTANCES

6.1 CONDITIONS FOR PRIVILEGES OF DENTISTS

6.1-1 Admissions

Dentists who are Members of the Medical Staff may only co-admit patients, if a Physician Member of the Medical Staff agrees to conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or except as otherwise provided by the Medical Executive Committee) and will assume responsibility for medical problems, present at the time of the co-admission or which may arise during hospitalization, which are outside of the dentists lawful scope of practice.

6.1-2 Surgery

Surgical procedures performed by dentists will be under the overall supervision of the Medical Director of Surgery or his or her designee.

6.1-3 Medical Appraisal

All patients co-admitted for care in the Hospital by a dentist, if necessary for the delivery for competent care, will be evaluated by a Physician Member, upon arrangement by the dentist, to determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a Physician Member and dentist based upon medical or surgical factors outside of the scope of licensure of the dentist, the treatment will be suspended insofar as possible while the dispute is resolved by the Chief of Staff or his or her designee.

6.2 CONDITIONS FOR PRIVILEGES OF PODIATRISTS

6.2-1 Admissions

Podiatrists who are Members of the Medical Staff may only co-admit patients if a Physician Member of the Medical Staff agrees to conduct or directly supervise the admitting history and physical examination (except the portion related to podiatry) or except as otherwise may be provided by the Medical Executive Committee, and will assume responsibility for medical problems, present at the time of the co-admission or which may arise during hospitalization, which are outside of the podiatrist's lawful scope of practice.

6.2-2 Surgery

Surgical procedures performed by podiatrists will be under the overall supervision of the Medical Director of Surgery or his or her designee.

6.2-3 Medical Appraisal

All patients co-admitted for care in the Hospital by a podiatrist will receive the same basic medical appraisal as patients admitted to other services, and a Physician Member, upon arrangement by the podiatrist, will determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a Physician Member and podiatrist based upon medical or surgical factors outside of the scope of licensure of the podiatrist, the treatment will be suspended insofar as possible while the dispute is resolved by the Chief of Staff of his or her designee.

6.3 CONDITIONS FOR PRIVILEGES OF SURGEONS. Surgery may only be performed by a doctor of medicine or osteopathy, dental surgery or dental medicine or podiatric medicine.

6.4 TEMPORARY CLINICAL PRIVILEGES

6.4-1 Circumstances

- (a) In cases of medical necessity, temporary Clinical Privileges may be granted to a Practitioner for the care of specific patients (but not more than one hundred twenty days(120) days during a calendar year) provided that the procedure described in Section 6.4-2(a) has been followed.
- (b) Following the procedure in Section 6.4-2(a), temporary privileges may also be granted to a Practitioner serving as a locum tenens for a current Member of the Medical Staff or when additional coverage is deemed necessary by the Chief of Staff, or his or her designee. Such person may provide coverage, for a period not to exceed ninety (90) days, unless the Chief of Staff, or his or her designee, recommends a longer period for good cause.

- (c) In cases of new applicants awaiting review and approval by the Medical Staff provided the procedures described in Article 6.4-2(a) and (b) have been followed. Such person may provide coverage for a period not to exceed one hundred and twenty (120) days.

6.4-2 Application and Review

- (a) Upon receipt of a completed application from a Practitioner authorized to practice in Minnesota, the Governing Body, acting through the Chief of Staff and/or CEO or his or her designee, may grant temporary privileges to a Practitioner who appears to have qualifications, ability and judgment, consistent with these bylaws, but only after:
- (i) The Chief of Staff, or his or her designee, has interviewed the Applicant and has contacted at least two persons (interviews and contacts may be by telephone) or by written evaluations who:
- Have worked with the Applicant during the prior twelve (12) months.
 - Have directly observed the Applicant's professional performance over a reasonable period of time.
 - Can provide reliable information regarding the Applicant's current professional competence and character.
 - This information will be documented on the Temporary Privileges Form and filed in the credentials file.
- (ii) Confirmation is received concerning licensure, malpractice insurance coverage and applicable DEA registration.
- (iii) An inquiry is submitted to and answered by the National Practitioner Data Bank.
- (iv) After reviewing the Applicant's file and attached materials, the Medical Executive Committee, through the Chief of Staff or his or her designee, recommends granting temporary privileges.
- (b) In cases of new applicants awaiting review and approval by the Medical Staff, the Chief of Staff must also verify the following:
- (i) The applicant has no current pending complaint with the Minnesota Board of Medical Practice nor any previous disciplinary action by that Board.

- (ii) The applicant was not subjected to involuntary termination of Medical Staff membership at another organization or an involuntary limitation, reduction, denial or loss of clinical privileges.
- (c) After temporary privileges have been granted, the Applicant's file, and all attached materials, will be forwarded to the Credentials Committee.

6.4-3 General Conditions

- (a) If granted temporary privileges, the Practitioner will act under the supervision of a Physician Member of the Medical Staff of that specific department as appointed by the Chief of Staff and the Chief of Staff will be kept closely informed as to the Practitioner's activities within the facility.
- (b) Temporary privileges will automatically terminate at the end of the designated period, unless earlier terminated by the Medical Executive Committee upon recommendation of the Chief of Staff or the Credentials Committee or unless affirmatively renewed following the procedure as set forth in Section 6.5-2.
- (c) Requirements for proctoring and monitoring will be imposed on such terms as may be appropriate under the circumstances upon any Practitioner granted temporary privileges by the Governing Body, acting through the CEO or his or her designee, after consultation with the Chief of Staff or his designee.
- (d) Temporary privileges may be immediately terminated at any time by the CEO or the Chief of Staff, subject to prompt review by the Medical Executive Committee and the Governing Body. In such cases, the Chief of Staff will assign a Member of the Medical Staff to assume the responsibility for the care of such Practitioner's patient(s). The wishes of the patient will be considered in the choice of a replacement Medical Staff Member.
- (e) A Practitioner with temporary privileges is not a Member of the Medical Staff and, therefore, is not entitled to the procedural rights afforded by Article 11 because a request for temporary privileges is refused or because all or any portion of temporary privileges are terminated or suspended.
- (f) All Practitioners requesting or receiving temporary privileges will be bound by the bylaws, rules and regulations and policies of the Medical Staff and the Hospital.

6.5 EMERGENCY PRIVILEGES

- (a) In the case of an Emergency, any Member of the Medical Staff, to the degree permitted by his or her license and regardless of Medical Staff status or Clinical Privileges, will be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm.

The Member will make a 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, will defer to the Chief of Staff with respect to further care of the patient at the Hospital.

- (b) In the event of an Emergency, any person will be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons will promptly yield such care to qualified Members of the Medical Staff when such persons become reasonably available.

6.6 DISASTER PRIVILEGES

- (a) Practitioners who do not possess Clinical Privileges at the Hospital may be granted disaster privileges to volunteer licensed independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the Hospital is unable to meet immediate patient needs. The Chief Executive Officer or Chief of Staff or their designee will be responsible for granting disaster privileges.
- (b) Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the Hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:
 - (i) A current picture identification card from a health care organization that clearly identifies professional designation
 - (ii) A current license to practice
 - (iii) Primary source verification of licensure
 - (iv) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT, the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group.
 - (v) Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
 - (vi) Confirmation by a licensed independent practitioner currently privileged by the Hospital or by a staff member with personal knowledge

of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

- (c) Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization, or whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances the Hospital documents all of the following:
 - (i) Reason(s) it could not be performed within 72 hours of the practitioner's arrival
 - (ii) Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services
 - (iii) Evidence of the Hospital's attempt to perform primary source verification as soon as possible
 - (iv) If due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible
- (d) The Chief Executive Officer or Chief of Medical Staff will assign practitioners to appropriate departments and supervision physicians.
- (e) The Medical Staff will oversee the volunteer practitioners with disaster privileges by direct observation or clinical record review.
- (f) The practitioner shall act only under the supervision of a current Medical Staff Member of the same specialty, if possible.
- (g) The hospital decides within 72 hours whether to continue the disaster privileges.

6.7 TELEMEDICINE

Riverwood will accept the telemedicine practitioners credentialing and privileging information from the distant site if it is a Joint Commission accredited organization. For the purposes of these bylaws, telemedicine is defined as the use of electronic communication or other communication technologies to provide or support clinical care from a distance. The Medical Staff, as set forth herein, will determine which clinical services are appropriately delivered through this medium, according to commonly accepted quality standards.

ARTICLE 7. OFFICERS

7.1 OFFICERS OF THE MEDICAL STAFF

7.1-1 Identification

The officers of the Medical Staff will be the Chief of Staff and the Vice Chief of Staff.

7.1-2 Qualifications

Officers must be Members of the Active Medical Staff at the time of their nomination and election, and must remain such Members in Good Standing during their terms of office. Candidates for office will have demonstrated executive and administrative ability through experience and prior constructive participation in Medical Staff activities and be recognized by their peers for their clinical competence and leadership skills. Failure to maintain such status will create a vacancy in the office involved.

7.1-3 Nominations

Nominations will be made by the Medical Staff Executive Committee in writing prior to the September Medical Executive Committee meeting, provided the nominee consents.

7.1-4 Elections

- (a) Officers will be elected at the October meeting of the Medical Staff and approved by the Governing Body, which approval will not be unreasonably withheld. Only Members of the Active Medical Staff are eligible to vote.
- (b) In the event of three or more candidates, with no candidate receiving a majority vote, the candidate with the fewest votes will be dropped from the list. Successive balloting, omitting the name with the fewest votes from each slate, will continue until a majority vote is achieved for one candidate.

7.1-5 Term of Elected Office

Each officer will serve a four (4) year term, other than the Chief of Staff, who will serve a four (4) year term, commencing on the first day of the Medical Staff year following his or her election. Each officer will serve in each office until the end of his or her term, or until a successor is elected, unless he or she resigns or is removed from office.

7.1-6 Recall of Officers

Recall of a Medical Staff officer may be initiated for a Specified Cause by a majority vote of the Medical Executive Committee, by a petition signed by at least one-third of the Members of the Medical Staff eligible to vote for officers or by the Governing Body. Recall will be considered at a special meeting of the Medical Staff called for that purpose. Recall will require a two-thirds vote of the Medical Staff Members eligible to vote for Medical Staff officers who actually cast votes at the special meeting in person or by mail ballot.

7.1-7 Vacancies in Elected Office

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership on the Medical Staff. Vacancies, other than that of Chief of Staff, will be filled by appointment by the Medical Executive Committee until the next Annual Meeting. If there is a vacancy in the office of Chief of Staff, the then Vice Chief of Staff will serve out that remaining term.

7.2 DUTIES OF OFFICERS

7.2-1 Chief of Staff

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

- (a) Enforcing the bylaws, and rules and regulations and policies of the Medical Staff and of the Hospital, implementing sanctions where indicated, and promoting compliance with procedural safeguards where disciplinary action has been requested or initiated.
- (b) Calling, presiding at, and being responsible for the agenda of all Medical Staff meetings.
- (c) Serving as chairman of the Medical Executive Committee.
- (d) Serving as an ex officio member of all other Medical Staff committees. As an ex officio member of such committees, the Chief of Staff will have no vote, unless his or her vote in a particular committee is otherwise required by these bylaws.
- (e) Interacting with the CEO and Governing Body in all matters of mutual concern within the Hospital.
- (f) Appointing, in consultation with the Medical Executive Committee, committee members for all standing and special Medical Staff liaison or multi-disciplinary committees, except where otherwise provided by these

bylaws and, except where otherwise indicated, designating the chairman of these committees.

- (g) Representing the views and policies of the Medical Staff to the Governing Body and to the CEO.
- (h) Being a spokesperson for the Medical Staff in professional and public relations situations.
- (i) Performing such other functions as may be assigned by these bylaws, the Medical Staff or the Medical Executive Committee.
- (j) Serving on liaison committees with the Governing Body and Administration, as well as outside licensing or accreditation agencies.
- (k) Reporting to the Governing Body on the actions and recommendations of the Medical Staff, including quality of care issues, and presenting and interpreting policies of the Governing Board to the Medical Staff.

7.2-2 Vice Chief of Staff

The Vice Chief of Staff will assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff will be a member and the vice-chairman of the Medical Executive Committee of the Medical Staff and will perform such other duties as the Chief of Staff may assign or as may be delegated by these Medical Staff Bylaws or by the Medical Executive Committee.

7.3 MEDICAL DIRECTORS

7.3-1 Purpose

The Medical Staff will be organized in all respects as a committee-of-the-whole except as specifically provided otherwise in these Bylaws. However, Medical Directors will be appointed in accordance with Section 7.3-3 below. The general purpose of medical directorships will be to provide clinical supervision for the following clinical service areas and to serve as a basis for communication and coordination with the Medical Staff.

- General Surgery
- Emergency Room
- Hospice
- Nutrition
- Laboratory and Blood Bank
- Cardiopulmonary and Critical Care

- OB/Newborn/Peds
- Anesthesia
- Radiology and Imaging
- Rehab Services/Ortho
- Occupational Health/Work Comp
- Pharmacy
- Wound Care
- Diabetes Education
- Rural Health Clinics
- Infusion

7.3-2 Qualifications

Each Medical Director will be the Medical Staff member most qualified to work with the clinical service area to which he is appointed. As a general rule, he or she should be a member of the Active Staff; however, a Courtesy Staff member may be appointed if he or she is deemed more qualified, due to specialty, than any Active Staff member.

7.3-3 Selection

Medical Directors will be appointed by the Chief of Staff at the Annual Meeting of the Medical Staff and a list of medical directors so appointed will be submitted to the Governing Body for approval.

7.3-4 Term of Office

A Medical Director will serve a four-year term commencing with his or her appointment. Each Medical Director will serve until the end of the Medical Staff Year or until a successor is chosen. A Medical Director will be eligible to succeed himself. Removal of a Medical Director from office may be effected by the Governing Body acting on its own authority, or upon the recommendation of the Medical Staff. The procedural rights set forth in Article 11 will not apply.

7.3-5 Duties

Each Medical Director will:

- (a) Exercise general supervision for the Medical Staff over the clinical work performed within his or her clinical service area.

- (b) Help develop and implement programs and policies to carry out the performance improvement functions assigned to his or her clinical area.
- (c) Help develop and implement continuing education programs for his or her clinical service area.
- (d) Help coordinate the activities of his or her clinical service area through cooperation with the hospital administration, nursing service and the Medical Staff as a whole.
- (e) Report on at least a quarterly basis to the Medical Executive Committee and/or the Medical Staff.

7.3-6 Functions of Clinical Service Areas

The general functions of each clinical service area will include as needed:

- (a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the clinical service area. The number of such reviews to be conducted during the year will be as determined by the Medical Executive Committee in consultation with other appropriate committees. Information will be routinely collected about important aspects of patient care provided in the clinical service area, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews will include all clinical work performed under the jurisdiction of the clinical service area.
- (b) If requested, recommending to the Medical Executive Committee, for approval by the Governing Body, the professional criteria for the granting of Clinical Privileges and the performance of specified services within the clinical service area, together with the assessment and recommendation of off-site sources for needed patient care not provided by the Hospital.
- (c) If requested, evaluating and making appropriate recommendations regarding the qualifications of Applicants seeking appointment or reappointment and Clinical Privileges within that clinical service area, together with general recommendations for a sufficient number of qualified persons to provide care.
- (d) Conducting, participating and making recommendations regarding orientation and continuing education programs pertinent to the area's clinical practice.
- (e) Reviewing and evaluating adherence to Medical Staff policies and procedures and sound principles of clinical practice.

- (f) Coordinating patient care provided by the clinical service area with nursing and ancillary patient care services and with the services provided by other clinical service areas and external parties when necessary.
- (g) Reviewing all mortalities, unless such review is otherwise handled under these bylaws or the Medical Staff Rules and Regulations.
- (h) Submitting written reports to the Medical Executive Committee concerning review and evaluation activities, actions taken thereon, and the results of such action and recommendations for maintaining and improving the quality of care, according to performance improvement standards, provided in the clinical service area and the Hospital.
- (i) Establishing and appointing such committees or other mechanisms as are necessary and desirable to perform and properly support the functions assigned to it, including proctoring protocols.
- (j) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.
- (k) Accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the clinical service area.
- (l) Determining the qualifications and competence of personnel who are not Members of the Medical Staff and who provide patient care services in the clinical service area.
- (m) Reviewing and recommending policies and procedures to ensure that all Practitioners with Clinical Privileges only provide services within the scope of the privileges granted.
- (n) Formulating recommendations for rules and regulations reasonably necessary for the proper discharge of its responsibilities consistent with these bylaws and subject to the approval by the Medical Executive Committee and the Governing Body.

7.3-7 Discharge of Functions

The discharge of the functions described above in Section 7.3-6 will be the responsibility of the Medical Executive Committee, acting through the Medical Directors and in concert with Administration.

ARTICLE 8. COMMITTEES

8.1 DESIGNATION

Medical Staff committees will include, but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of committees established under this Article 8, and meetings of special or ad hoc committees created by the Medical Executive Committee. The committees described in this Article will be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee or Chief of Staff to perform specified tasks. Unless otherwise specified, the chairman and voting members of all committees must be Members of the Medical Staff and will only be appointed by, and may only be removed by, the Chief of Staff, who can remove them without cause. Medical Staff committees will be responsible to the Medical Executive Committee. Unless otherwise specified, the CEO will appoint all committee members who are not Members of the Medical Staff.

8.2 GENERAL PROVISIONS

8.2-1 Term of Committee Members

Unless otherwise specified, committee members will be appointed for a term of two (2) years, and will serve until the end of this period or until the member's successor is appointed, unless the member resigns or is removed from the committee. Unless otherwise provided for herein or by the Medical Executive Committee when creating special or ad hoc committees, committee members who are not Members of the Medical Staff, will be ex officio committee members with no vote.

8.2-2 Removal

If a member of a committee ceases to be a member in Good Standing of the Medical Staff, suffers a loss or significant limitation of Clinical Privileges, fails to regularly attend meetings, or if any other good cause exists, that member may be removed from committee membership by the Medical Executive Committee without any procedural rights under Article 11.

8.2-3 Vacancies

Unless otherwise specifically provided, vacancies on any committee will 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.

8.3 MEDICAL STAFF COMMITTEE-OF-THE-WHOLE

8.3-1 Composition

The Medical Staff Committee-of-the-Whole will consist of all Active Members of the Medical Staff in Good Standing. The Chief of Staff will serve as Chairman and preside at meetings. The Chief Executive Officer will be an ex-officio member without vote.

8.3-2 Duties

The duties of the Medical Staff Committee-of-the-Whole will be to:

- (a) Receive and act upon reports and recommendations from other standing and special committees and officers of the staff.
- (b) Coordinate the activities of and policies adopted by the Medical Staff.
- (c) Account to the Governing Body on the overall quality and efficiency of medical care rendered to patients in the Hospital.
- (d) Initiate and pursue disciplinary action, when warranted, in accordance with Articles 10 and 11.
- (e) Make recommendations on medico-administrative and Hospital matters.
- (f) Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.

8.3-3 Meetings

The Medical Staff will meet biannually and maintain a record of its proceedings and actions.

8.4 MEDICAL EXECUTIVE COMMITTEE

8.4-1 Composition

The Medical Executive Committee will consist of the following persons:

- (a) The then serving officers of the Medical Staff (Chief of Staff and Vice Chief of Staff)
- (b) The CMO, ER Director, Medical Director for Surgery or designee, and one at-large member.
- (c) The CEO, or his or her designee, as an ex officio non-voting member, Director of Quality and Risk Management.

- (d) The QA Secretary as an ex officio non-voting member.

8.4-2 Duties

Duties of the Medical Executive Committee will include, but not be limited to:

- (a) Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these bylaws.
- (b) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff.
- (c) Receiving and acting upon reports and recommendations from Medical Staff committees and assigned activity groups.
- (d) Recommending action directly to the Governing Body on Medical Staff matters.
- (e) Recommending to the Governing Body the structure of the Medical Staff, the mechanism to review credentials and delineate individual Clinical Privileges, the organization of performance improvement activities and mechanisms of the Medical Staff, termination of Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff.
- (f) Evaluating the medical care rendered to patients in the Hospital.
- (g) Participating in the development of all Medical Staff policies and all Hospital policies, practices and plans directly affecting the Medical Staff.
- (h) Reviewing the qualifications, credentials, performance and professional competence and character of Applicants and Medical Staff Members and making recommendations to the Governing Body regarding Medical Staff appointments, Clinical Privileges, and corrective action.
- (i) Taking reasonable steps to promote professional conduct and competent clinical performance on the part of all Members including the initiation of and participation in Medical Staff corrective or review measures when warranted.
- (j) Taking reasonable steps to develop continuing education activities and programs for the Medical Staff.
- (k) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff.

- (l) Reporting to the Medical Staff at each regular Medical Staff meeting.
- (m) Assisting in the obtaining and maintaining of accreditation.
- (n) Participate in the development and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster.
- (o) Establishing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff.
- (p) Nominate candidates every two (2)four (4) years for Medical Staff officers.
- (q) Accounting to the Governing Body, by written report, on the quality and appropriateness of medical care provided to patients of the Hospital, including summaries of specific findings, actions and follow-up.

8.4-3 Meetings

The Medical Executive Committee will meet monthly, except the months of Medical Staff Committee meetings as a whole, or as needed and on the call of its chairman, will maintain a record of its proceedings and actions and will report to the Governing Body.

8.4-4 Membership Eligibility

No Medical Staff Member actively practicing in the Hospital is ineligible for membership on the Medical Executive Committee solely because of his or her professional discipline or specialty. Notwithstanding, a majority of the voting members of the Medical Executive Committee must be Physician Members of the Medical Staff actively practicing at the Hospital.

8.5 CREDENTIALS COMMITTEE

8.5-1 Composition

The Credentials Committee will consist of not less than three Members of the Medical Staff and must include the Chief of Staff, a surgeon and the ED Medical Director, and one non-voting representative from Administration. If one physician is assuming dual roles, another physician will be appointed for the committee.

8.5-2 Duties

The Credentials Committee will:

- (a) Oversee the creation, maintenance and use of credentialing policies, procedures, forms and criteria for the granting and evaluation of Clinical Privileges.
- (b) Endeavor to ensure that established policies and procedures are followed regarding applications, reapplications and requests for Clinical Privileges.
- (c) Oversee the development by each clinical service area of objective criteria to measure the clinical skill and performance of Practitioners.
- (d) Maintain accurate and complete documentation concerning the entire credentialing process, including the establishment, maintenance, storage, security and retrieval of credentials files, committee minutes and other documents pertaining to the processing of individual applications for appointment to the Medical Staff and the granting of Clinical Privileges.
- (e) Establish, review and revise, in conjunction with the appropriate clinical service areas, the criteria for the delineation of clinical privileges, including the development and use of Medical Staff profiles for recredentialing.
- (f) Review and evaluate the qualifications of each Practitioner applying for initial appointment, reappointment or modification of and for Clinical Privileges and, in connection therewith, obtain and consider the recommendations of the appropriate Medical Director.
- (g) Submit required reports and information on the qualifications of each Practitioner applying for membership or particular Clinical Privileges including recommendations with respect to appointment, membership category, Clinical Privileges and special conditions.
- (h) Investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any Applicant or Medical Staff Member.
- (i) Submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.

8.5-3 Meetings

The Credentials Committee will meet quarterly and on the call of its chairman. The committee will maintain a record of its proceedings and actions and will report to the Medical Executive Committee.

8.6 MEDICAL STAFF BYLAWS COMMITTEE

8.6-1 Composition

The Medical Staff Bylaws Committee will consist of at least two Members of the Active Medical Staff, including the Chief of Staff or his or her designee.

8.6-2 Duties

The duties of the Medical Staff Bylaws Committee will include:

- (a) Conducting an annual/periodic review of the Medical Staff Bylaws as needed or every two years.
- (b) Submitting recommendations to the Medical Staff for changes in these documents as necessary to reflect current Medical Staff practices.
- (c) Receiving and evaluating, for recommendation to the Medical Staff, suggestions for modification of the Medical Staff Bylaws, as well as the rules, regulations, policies and forms used by the Medical Staff.

8.6-3 Meetings

The Medical Staff Bylaws/Nominating Committee will meet at the call of its chairman and as otherwise required by these bylaws.

8.7 MEDICAL STAFF QUALITY COMMITTEE

8.7-1 Composition

The Medical Staff Quality Committee will consist of five (5) members, majority need to be Active Medical Staff members and include balanced representation from the main clinical specialty areas of the Hospital. Practitioners from other specialties may be invited to attend Medical Staff Quality Committee meetings as needed.

8.7-2 Duties

The duties of the Medical Staff Quality Committee will include:

- (a) Define Practitioner performance indicators and targets for the General Competencies in collaboration with the appropriate departments and specialties and approved by the Medical Executive Committee.
- (b) Evaluate Practitioner performance for these indicators to determine if improvement opportunities exist either through case review or using aggregate data for patterns and trends.

- (c) Assure accountability by appropriate Medical Staff leader for the development of improvement plans when appropriate.
- (d) Oversee any other Medical Staff specialty specific peer review activities.

8.7-3 External Review

In addition to the quality review conducted by the Medical Staff Quality Committee, the quality and appropriateness of the diagnosis and treatment of the treatment provided at the Hospital shall be periodically evaluated by one quality improvement organization or equivalent entity. The Medical Staff will review this evaluation and take any necessary corrective action.

8.8 ETHICS COMMITTEE

8.8-1 Composition

The Ethics Committee will consist of members who are multidisciplinary that come together to provide an environment in which conscious and reflective consideration can be given to significant and often ambiguous value issues in patient care.

8.8-2 Duties

- (a) Provide bioethics education to employees of Riverwood Health Care Center;
- (b) Enable Hospital to identify, clarify and analyze ethical issues in patient care;
- (c) Improve the quality of patient care;
- (d) Look at issues morally;
- (e) Establish a moral standard of care.

8.9 CANCER COMMITTEE

8.9-1 Composition

The Cancer Committee shall be appointed by the Chief of Staff and shall consist of, but not be limited to, a multidisciplinary representation of physicians from diagnostic and treatment specialties, as well as non-physicians from administrative and support services. Physician providing cancer care for patients are board certified or in the process of becoming board certified. Required members are: Cancer Liaison Physician, Cancer Committee Chair, Surgeon, Medical Oncologist, Diagnostic Radiologist, Pathologist. Required non-physician member are: Oncology Program Director, Oncologist nurse, Quality Management, Certified Tumor Registrar, Social Worker, Community outreach Coordinator, Psychosocial Services Coordinator. The Subcommittees will update the Cancer Committee at

quarterly meetings regarding discussion and activity of specified standards. Please refer to Policy 56-6 for more information.

8.9-2 Duties

The duties of the Cancer Committee will include:

- (a) Assure that all cancer patients are provided high quality multidisciplinary care and services from prevention/detection through end-of-life;
- (b) Assure that cancer treatment planning conferences cover the spectrum of major cancer diagnosis, provide a forum for patient consultation, and contribute to physician education;
- (c) Uphold and abide by current American College of Surgeons Commission on Cancer Program Standards.

8.9-3 Meetings

The Cancer Committee will meet at least quarterly to fulfill its responsibilities.

ARTICLE 9. MEETINGS

9.1 MEETINGS

9.1-1 Regular Meetings

Regular meetings of the Members will be held biannually. The date, place and time of the regular meetings will be determined by the Chief of Staff, and adequate notice will be given to the Members.

9.1-2 Agenda

The order of business at a meeting of the Medical Staff will be determined by the Chief of Staff. The agenda will include, insofar as feasible:

- (a) Acceptance of the minutes of the last regular meeting and all special meetings held since the last regular meeting.
- (b) Administrative reports from the Chief of Staff and the CEO.
- (c) Election of officers when required by these bylaws.
- (d) Reports by responsible officers and committees on the overall results of patient care audits and other quality review, evaluation, and monitoring

activities of the Medical Staff and on the fulfillment of other required Medical Staff functions.

- (e) Old business.
- (f) New business.

9.1-3 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, the Medical Executive Committee, the Governing Body, or will be called upon by written request of twenty-five percent (25%) of the Members of the Active Medical Staff. The person calling or requesting the special meeting will state the purpose of such meeting in writing. The meeting will be scheduled by the Medical Executive Committee within twenty (20) days after receipt of such request. No later than ten (10) days prior to the meeting, notice will be mailed or delivered to the Members of the Medical Staff which includes the stated purpose of the meeting. No business will be transacted at any special meeting except that stated in the notice calling the meeting.

9.2 COMMITTEE MEETINGS

9.2-1 Regular Meetings

Except as otherwise specified in these bylaws, the chairmen of committees may establish the times for the holding of regular meetings. The chairmen will make every reasonable effort to ensure the meeting dates and times are disseminated to the Members with adequate notice.

9.2-2 Special Meetings

A special meeting of any Medical Staff committee may be called by the chairman thereof, the Medical Executive Committee, the Governing Body or the Chief of Staff, and will be called by written request of one-third of the current Members thereof eligible to vote, but not less than two Members.

9.3 QUORUM

9.3-1 Medical Staff Meetings

The presence of fifty percent (50%) of the Active Medical Staff plus one at any regular or special meeting will constitute a quorum for the transaction of all business.

9.3-2 Medical Executive Committee Meetings

The presence of fifty percent (50%) of the voting members of the Medical Executive Committee plus one will constitute a quorum for the transaction of its business.

9.3-3 Committee Meetings

Except as provided in Section 9.3-2, the presence of fifty percent (50%) of the voting Members of the Medical Staff on the committee plus one will constitute a quorum for the transaction of business of the committee, provided such quorum will not be fewer than two (2) such Members.

9.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the Members present and voting at a meeting at which a quorum is present will be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of Members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone conference which will be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee, if it is acknowledged by a writing setting forth the action so taken which is signed by all of the Members entitled to vote.

9.5 MINUTES

Except as otherwise specified herein, minutes of meetings will be prepared and retained. They will include, at a minimum, a record of the attendance of Members, votes taken on significant matters and related action plans. A copy of the minutes will be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee.

9.6 ATTENDANCE REQUIREMENTS

9.6-1 Regular Attendance

Except as stated below, each Member of the Active Staff, and all provisional Members of the Active Staff during the term of appointment who are entitled to attend meetings under Article 4, will be required during each Medical Staff year to attend:

- (a) Must attend at least fifty percent (50%) of the meetings.
- (b) At least fifty percent (50%) of all duly convened meeting of committees to which he or she has been elected or appointed and in which he or she is a voting member.

- (c) It will be the responsibility of the Practitioner to satisfactorily document compliance with these requirements.

Each Member of the Consulting or Courtesy Staff and all provisional Members of the Courtesy or Consulting Staff will be required to attend such other meetings as may be determined by the Medical Executive Committee.

9.6-2 Absence from Meetings

Any member who is compelled to be absent from any Medical Staff or committee meeting will promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer or the committee or the secretary for the Medical Staff meetings, failure to meet the attendance requirements may be grounds for removal from such committee or for disciplinary action.

9.6-3 Special Attendance

At the discretion of the chairman or presiding officer, when a Member's practice or conduct is scheduled for discussion at a regular or special committee meeting, the Member may be requested to attend. If a suspected deviation from standard clinical practice is involved, a notice will be given at least ten (10) days prior to the meeting and will include the time and place of the meeting and a general indication of the issue involved. Failure of a Member to appear at any meeting with respect to which he was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, will be a basis for disciplinary action.

9.7 CONDUCT OF MEETINGS

Unless otherwise specified herein, meetings will be conducted according to Robert's Rules of Order. However, technical or non-substantive departures from such rules will not invalidate action taken at such a meeting.

9.8 CONFIDENTIALITY

The discussions, actions, minutes and records of the Medical Staff and its committees are strictly confidential and will not be disclosed to individuals or groups within or outside of the Hospital or its Corporate Member, except as is required by law, these bylaws, or by the Hospital or its Corporate Member, or by their bylaws. Failure to maintain this confidentiality may subject a Member of the Medical Staff to disciplinary action under these bylaws.

ARTICLE 10. DISCIPLINARY PROCEDURES

10.1 CORRECTIVE ACTION

10.1-1 Criteria for Initiation

Any person may provide information to the Chief of Staff or the Medical Executive Committee about the conduct, performance, or competence of a Member. When reliable information indicates that a Member may have exhibited acts, demeanor or conduct reasonably likely to be (1) detrimental to a patient's or anyone's safety or to the delivery of patient care within the Hospital; (2) contrary to the Medical Staff or Hospital Bylaws or Rules and Regulations; or (3) below applicable professional standards, a request for an investigation or action against such Member may be initiated by the Chief of Staff, the CEO, the Governing Body or the Medical Executive Committee.

10.1-2 Initiation

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it will make an appropriate record of its reasons.

10.1-3 Investigation

If the Medical Executive Committee concludes that an investigation is warranted, it will direct that an investigation be undertaken, and when appropriate, conduct a Focused Professional Practice Evaluation in accordance with the procedures set forth in the Medical Staff Policies with notice to the CEO. The Chief of Staff or designee may meet with the practitioner on a one-to-one basis. The Chief of Staff or designee will determine if this needs to go on for further investigation. The involved practitioner may ask to come to the Medical Staff Committee for follow-up. The Medical Executive Committee will assign the task to an ad hoc committee of the Medical Staff composed of members who are not, to the extent practical, in direct economic competition with the individual under investigation. The committee will proceed with its investigation in a prompt manner and will forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate disciplinary action or no action at all. The Member will promptly be notified that an investigation is being conducted and will be given an opportunity to provide information in a manner and upon such terms as the ad hoc committee deems appropriate. The ad hoc committee may, but is not obligated to, conduct interviews with persons involved, however, such investigation will not constitute a "hearing" as that term is used in Article 11, nor will the procedural rules with respect to hearings apply. Despite the status of any investigation, the Medical Executive Committee and the Governing Body will at all times retain authority and discretion

to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process or other action.

10.1-4 Medical Executive Committee Action

As soon as practicable after the conclusion of the investigation by the ad hoc committee, the Medical Executive Committee will, with notice to the CEO, take action which may include, without limitation:

- (a) Determining no disciplinary action be taken.
- (b) Deferring action for a reasonable time where circumstances warrant.
- (c) Issuing letters of admonition, warning, reprimand or censure, although nothing herein will be deemed to preclude a Medical Staff Officer or a Medical Director from issuing informal written or oral warnings outside of the mechanism for corrective action in this Article. In the event such letters are issued, the affected Member may make a written response which will be placed in the Member's file.
- (d) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or the exercise of Clinical Privileges including, without limitation, requirements for co-admission, mandatory consultation or monitoring.
- (e) Recommending reduction, modification, suspension or revocation of Clinical Privileges or admitting privileges.
- (f) Recommending reductions of membership status or limitation of any prerogatives directly related to the Member's delivery of patient care.
- (g) Recommending suspension, modification, probation or revocation of Medical Staff membership.

10.1-5 Subsequent Action

- (a) If disciplinary action as set forth in subsections (d) through (g) of Section 10.1-4 is recommended by the Medical Executive Committee, that recommendation will be transmitted in writing to the Member in accordance with the requirements set forth in Article 11.2. In these cases only, the Member will then be entitled to his or her rights as set forth in Article 11.
- (b) If the Member does not timely exercise his or her rights under Article 11, the Medical Executive Committee will forward its recommendation to the Governing Body.
- (c) The decision of the Governing Body will be deemed final action.

10.1-6 Remediation

Notwithstanding the foregoing, the Medical Executive Committee may, in the alternative and with notice to the CEO and the appropriate Medical Director, enter into a remedial agreement with the affected Member to resolve the problem at issue. If the affected Member fails to abide by the terms of the remedial agreement, the Member will be subject to the standard corrective action procedures of this Article 10.

10.2 SUMMARY RESTRICTION OR SUSPENSION

10.2-1 Criteria for Initiation

Whenever a Member's conduct appears to require that immediate action be taken to protect the life or well-being of a patient or wherever the Member's conduct significantly disrupts Hospital operations or presents a danger of immediate and serious harm to the life, health, safety of any patient, prospective patient or other person, the Chief of Staff, the Medical Executive Committee, CEO or the Governing Body may summarily restrict or suspend the Medical Staff membership or Clinical Privileges of such Member. Unless otherwise stated, such summary restriction or suspension will become effective immediately upon imposition, and the person or body responsible will promptly give written notice to the Member, the Governing Body, the Chief of Staff, the Medical Executive Committee and the CEO. The summary restriction or suspension will remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the Member's patients will be promptly assigned to another Member by the Chief of Staff considering, where feasible, the wishes of the patient in the choice of a substitute Member.

10.2-2 Medical Executive Committee Action

As soon as practicable after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee will be convened to review and consider the action. The suspended Member may attend and make a statement concerning the issues under investigation on such terms and conditions as the Medical Executive Committee may impose. In no event will any meeting of the Medical Executive Committee, with or without the Member, constitute a "hearing" within the meaning of Article 11. The Medical Executive Committee may modify, continue or terminate the summary restriction or suspension, but in any event it will promptly furnish the Member, the CEO and the Governing Body with notice of its decision.

10.2-3 Procedural Rights

Unless the Medical Executive Committee terminates the summary restriction or suspension within fifteen (15) days of its effective date, the Member will be entitled to his or her rights as set forth in Article 11.

10.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the Member's Clinical Privileges or Medical Staff and prerogative membership may be suspended or limited as described, which action will be final without a right to hearing under Article 11 or further review.

10.3-1 Licensure

- (a) Revocation and Suspension. Whenever a Member's license or other legal credential authorizing practice in this State is revoked or suspended, the Member will immediately notify the CEO and his or her Medical Staff membership and Clinical Privileges will be automatically revoked as of the date such action becomes effective.
- (b) Restriction. Whenever a Member's license or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, the Member will immediately notify the CEO and any membership or Clinical Privileges which the Member has been granted at the Hospital which are within the scope of said limitation or restriction will be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- (c) Probation. Whenever a Member is placed on probation by the applicable licensing or certifying authority, the Member will immediately notify the CEO and his or her membership and Clinical Privileges will automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

10.3-2 Controlled Substances

- (a) Restriction. Whenever a Member's DEA certificate or prescribing authority is revoked, limited or suspended, the Member will immediately notify the CEO and the Member will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
- (b) Probation. Whenever a Member's DEA certificate or prescribing authority is subject to probation, the Member will immediately notify the CEO and the Member's right to prescribe such medications will automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

10.3-3 Failure to Satisfy Special Appearance Requirement

A Member, who, without good cause, fails to appear and satisfy the requirements of Section 9.6-3, will automatically be suspended from exercising all or such portion of Clinical Privileges as may be specified in accordance with the provisions of that Section.

10.3-4 Medical Records

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee. A suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, may be imposed after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, “related privileges” means on call service for the emergency room, scheduling surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital for future patients. Members whose privileges have been suspended for delinquent records may admit patients only in life threatening situations. The suspension will continue until lifted. Suspended Members may not admit patients under the name of another Member.

10.3-5 Professional Liability Insurance

A member who fails to maintain the level and type of professional liability insurance coverage as required by the Hospital will automatically be suspended from exercising all Clinical Privileges at the Hospital.

10.3-6 Exclusive Professional Services Contract

Unless otherwise specified in the contract, termination of an exclusive professional services contract or termination of a Practitioner’s relationship with the holder of an exclusive professional services contract will result in the automatic termination of an affected Practitioner’s membership on the Medical Staff and Clinical Privileges at the Hospital with no procedural rights under Article 11.

10.3-7 Executive Committee Deliberation

As soon as practicable after action is taken or warranted as described in Sections 10.3-1(b) or (c), Section 10.3-2, 10.3-3, 10.3-4, 10.3-5, or 10.3-6 the Medical Executive Committee will convene to review and consider the facts, and may recommend such further disciplinary action as it may deem appropriate following the procedures generally set forth commencing at Section 10.1.

ARTICLE 11. PROFESSIONAL REVIEW PROCEDURE

11.1 RIGHT TO HEARING

- (a) Except as otherwise provided for herein, any Practitioner whose appointment or reappointment to the Medical Staff or advancement in Medical Staff membership has been denied or any Practitioner whose Clinical Privileges have been curtailed, suspended, revoked or denied, or any Practitioner who has received any adverse recommendation from the Medical Executive Committee, Medical Staff or Governing Body, relative to a matter of Medical Staff appointment or Clinical Privileges (“adverse action”) will have the right to a formal hearing by a panel of individuals, a panel of individuals that includes a hearing officer or a hearing officer appointed by the Governing Body, or its designee. Neither the hearing officer nor any member of the panel will be in direct competition with the affected Practitioner. Nor will either have been involved in the formal evaluation of the affected Practitioner’s credentials or in the formulation of the adverse decision or recommendations. Any panel will consist of an odd number of Members, a majority of whom will be Physicians. No panel member or hearing officer is required to be a Member of the Medical Staff.
- (b) A Practitioner will not be permitted to reapply for any denied or terminated Medical Staff appointment, category or privilege for at least one (1) year following an adverse final decision by the Governing Body.

11.2 HEARING REQUIREMENTS

- (a) A Practitioner, who is the subject of an adverse action, will receive written notice from the CEO containing the following information: (i) a statement that an adverse action has been proposed or taken against the Practitioner; (ii) the reason for such adverse action; (iii) the Practitioner’s right to request a hearing on the adverse action; (iv) the time limits (of not less than thirty (30) days) within which to request such a hearing; and (v) a summary of rights as contained in this Article.
- (b) The Practitioner requesting a hearing must do so in writing, delivered in person or by certified mail to the CEO within thirty (30) days following receipt of any adverse action notice. If a hearing is not requested within thirty (30) days, the Practitioner will be deemed to have accepted the adverse action and it will become effective immediately and the Practitioner will have waived all rights due under the provisions of this Article.
- (c) The chairman of the panel or the hearing officer will arrange for the hearing and will give written notice through the Medical Staff Office to the requesting Practitioner of the time, place and date of the hearing which will take place not less than thirty (30) days after the date of notice. The Hospital may be represented by an attorney or any other person of the Hospital’s choice, who will fully participate in the hearing on the same basis as the practitioner’s attorney or representative. At least seven (7) days

prior to the commencement of the hearing, the Hospital will provide the Practitioner and the chairman of the panel or the hearing officer with a list of the witnesses expected to testify at the hearing on behalf of the Hospital and to the extent practical, with copies of all written materials to be introduced by the Hospital.

- (d) The Practitioner requesting the hearing will be entitled to be represented at the hearing by an attorney or any other person of the Practitioner's choice. The attorney or other person representing the Practitioner may participate fully in the hearing. Such representation will include, but will not be limited to, presentation of the Practitioner's case and examination and cross-examination of witnesses. At least seven (7) days prior to the commencement of the hearing, the Practitioner will provide a list of his or her witnesses to the chairperson of the panel or the hearing officer and, to the extent practical, with copies of all written material to be introduced by the Practitioner.
- (e) If a panel is appointed, it will select a chairman or appoint a hearing officer to preside over the hearing, if one has not been designated by the Governing Body, or its designee. This will be done by the hearing officer, when acting alone. Such chairperson or hearing officer will act to provide that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence and that decorum is maintained. Such chairman or hearing officer will be entitled to determine the order or procedure during the hearing. The hearing will not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. The chairman, hearing officer and members of the hearing panel may directly question any of the participants in the hearing, including witnesses. The panel or the hearing officer may engage, and consult with, an attorney or such other experts or advisors as they deem necessary.
- (f) The Practitioner and the Hospital will have the following rights:
 - (i) A record will be made of the proceedings, copies of which will be available to the Practitioner upon payment to the Hospital of any reasonable costs or charges associated with their preparation.
 - (ii) To call, examine and cross-examine witnesses.
 - (iii) To introduce evidence determined to be relevant by the chairman or hearing officer regardless of its admissibility in a court of law.
 - (iv) To impeach any witness.
 - (v) To rebut any evidence.
 - (vi) To submit a written statement at the close of the hearing.
 - (vii) To representation by an attorney or other person.

- (g) Petitioner will be deemed to have forfeited the right to a hearing if the Practitioner fails, without good cause, to appear.
- (h) The chairperson or hearing officer may recess the hearing and reconvene the same within fifteen (15) days for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, all without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing will be closed. The panel or hearing officer may, at a time convenient to themselves, conduct their deliberations outside the presence of the Practitioner for whom the hearing was convened.
- (i) Within fifteen (15) days of the final adjournment of the hearing, or as soon thereafter as practicable, the panel or hearing officer will make a written report and recommendation to the Governing Body. Such report and recommendation will include a statement of the basis for the recommendation. The report may recommend confirmation, modification, or rejection of the adverse action. A copy of that report and recommendation will be sent to the Practitioner on the same day it is forwarded to the Governing Body.
- (j) Within thirty (30) days, or as soon thereafter as practicable, after receipt of this report and recommendation, the Governing Body will render a written decision in the matter, including a statement of the basis for the Governing Body's decision, and will forward a copy of its decision to the CEO for transmittal to the Practitioner for whom the hearing was held. The decision of the Governing Body is final.

ARTICLE 12. GENERAL PROVISIONS ON GOVERNANCE

12.1 RULES AND REGULATIONS

The Medical Executive Committee will initiate and propose to adopt such Rules and Regulations as it may deem necessary for the proper conduct of the Medical Staff and will periodically (at least every two (2) years) review and propose to revise these Rules and Regulations to comply with current Medical Staff practice. Except in the case of urgent amendments to Rules and Regulations necessary to comply with law or regulation ("Urgent Amendments") all proposals shall be first communicated to the Active Medical Staff. The Medical Executive Committee may provisionally adopt and the Governing Body may provisionally approve Urgent Amendments without prior notification to the Active Medical Staff. The Active Medical Staff shall, however, be immediately notified of any Urgent Amendments and be granted the opportunity for retrospective review and comment. If the Active Medical Staff does not object to the Urgent Amendment, it shall stand. If the Active Medical Staff objects to the Urgent Amendment, it shall meet and confer with the Medical Executive Committee. If the parties are unable to agree on a resolution to the Urgent Amendment, both proposals shall be submitted to the Governing Body for resolution. Proposals for adoption or revision of Rules and Regulations will become effective with the approval of the Governing Body. Applicants and Members of the Medical Staff will be governed by such Rules and Regulations as are properly initiated and adopted.

Notwithstanding the foregoing, the Active Medical Staff may propose to adopt a Rule or Regulation, Policy or any amendments thereto; however, it shall first communicate the proposal to the Medical Executive Committee. In the event of a conflict between the Active Medical Staff and the Medical Executive Committee on issues related to this Article 12.1, the parties shall meet and confer to discuss resolution to the issue. If the parties are unable to agree on an acceptable resolution, proposals from both the Active Medical Staff and the Medical Executive Committee shall be submitted to the Governing Body for resolution. If there is a conflict between the Medical Staff Bylaws and the Rules and Regulations, the Medical Staff Bylaws will prevail; and if there is a conflict between or among the Medical Staff Rules and Regulations, the Medical Staff Bylaws and the bylaws of the Hospital, the bylaws of the Hospital will prevail. The mechanism described herein will be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations.

12.2 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these bylaws. These bylaws apply with equal force to both sexes wherever a gender term is used.

12.3 AUTHORITY TO ACT

Any Member or Members who act in the name of this Medical Staff or the Hospital without proper authority will be subject to such disciplinary action as the Governing Body deems appropriate or as determined by the Medical Executive Committee with the approval of the Governing Body.

12.4 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests required or permitted to be mailed will be in writing properly sealed, and will be sent through United States Postal Service, first class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or officers or committees thereof, will be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of committee
c/o Medical Staff Office
Riverwood Healthcare Center
200 Bunker Hill Drive
Aitkin, Minnesota 56431

Mailed notices to a Member, Applicant or other party, will be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

12.5 BYLAWS AMENDMENT

Upon the request of the Chief of Staff, the Medical Executive Committee, the Governing Body, the Medical Staff Bylaws Committee, or upon timely written petition signed by at least twenty-five percent (25%) of the Members of the Active Medical Staff in Good Standing who are entitled to vote, consideration will be given to the amendment, or repeal of these Medical Staff Bylaws. Such action will be taken at a regular or special meeting provided prior written notice of the proposed change was sent to all Members before the regular or special meeting of the Medical Staff at which action is to be taken, which notice will include the exact wording of the proposed changes(s). Notwithstanding the foregoing, when a Medical Staff Bylaws change is clearly mandated by law or regulation, the Chief of Staff will promptly call a special meeting of the Medical Staff, after receipt of a recommendation from the Medical Staff Bylaws Committee, to consider the proposed changes and the proposed changes will be included in the meeting notice sent to each Member. Nothing contained herein will supersede the general authority of the Hospital as set forth in its corporate bylaws or applicable common law or statutes.

12.6 ACTION ON BYLAW CHANGE

If a quorum is present for the purpose of enacting a bylaw change, the change will require an affirmative vote of a majority of the Members eligible to vote, voting in person or by written ballot.

12.7 APPROVAL

Bylaw changes recommended by the Medical Staff will become effective following approval by the Governing Body, which approval will not be unreasonably withheld. Members of the Medical Staff will be provided with a revised set of the Medical Staff Bylaws when significant changes have been made. With its approval of these Medical Staff Bylaws, and any amendments to them, the Governing Body agrees to uphold the same and expressly delegates certain of its legal responsibilities to the Medical Staff. However, this delegation is conditional and is not an abdication of the Governing Board's responsibilities or of its authority, so that it retains the power to act directly on any subject treated herein or as a result hereof.

ARTICLE 13: CONFIDENTIALITY AND IMMUNITY

Pursuant to MS § 145.64 (or any successor statute), all data and information acquired by any review organization (e.g., Medical Executive Committee) in the exercise of the Hospital's duties and functions for professional review, or by an individual or other entity acting at the direction of the Hospital and its professional review procedure, shall be held in strict confidence and shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the professional review procedure. No person who is involved in the professional review procedure may disclose what transpired at any meetings of the review organization, except to the extent necessary to carry out one or more of the purposes of the review organization. The proceedings and records that are generated in the context of the professional review procedure

shall not be subject to disclosure. Any witness who is involved in the professional review procedure cannot be asked about the witness' testimony relative to that procedure or opinions formed by the witness as a result of any hearings.

The confidentiality protection and protection from disclosure of information shall also apply to the Governing Body of the Hospital and shall not be waived as a result of referral of a matter from the review organization to the Governing Body, or consideration to the Governing Body of decisions, recommendations, or documentation of the review organization.

ADOPTED by the Medical Staff on _____, _____.

Joselito Burgos, MD, Chief of Staff

APPROVED by the Governing Body on _____, _____.

Michael Paulbeck, Chairman, Board of Trustees