ST. JOHN’S MEDICAL CENTER
MEDICAL STAFF BYLAWS

Approved by General Medical Staff: December 18, 2014
Approved by Board of Trustees: January 28, 2015
# ST. JOHN'S MEDICAL CENTER MEDICAL STAFF BYLAWS

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ST. JOHN’S MEDICAL CENTER
MEDICAL STAFF BYLAWS

PREAMBLE

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

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

DEFINITIONS

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

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

BOARD OF TRUSTEES or TRUSTEES means the St. John’s Medical Center District Board of Trustees, also referred to as the “board,” or “trustees.”

CHIEF EXECUTIVE OFFICER means the administrator of the Hospital or other individual appointed by the Board of Trustees to act in its behalf in the overall management of the Hospital.
CHIEF OF STAFF means the chief officer of the Medical Staff elected by members of the Medical Staff.

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

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

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

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

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

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

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

MEMBER means a physician who has been granted and maintains Medical Staff membership in good standing; a dentist, podiatrist, chiropractor or psychologist who has been granted and maintains Non-physician professional staff membership and clinical privileges in good standing; an allied health professional who has been granted and maintains allied health professional staff membership and clinical privileges in good standing

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

PRACTITIONER means, unless otherwise limited, any physician, dentist, podiatrist, psychologist, chiropractor, or allied health professional applying for, or exercising clinical privileges in, the Hospital.

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

STAFF means appointees to the Medical Staff, Non-physician Professional Staff or Allied Health Professional staff.
I. NAME, PURPOSES AND RESPONSIBILITIES

I.A. NAME

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

I.B. PURPOSES OF THE MEDICAL STAFF

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

   a. the benefits of membership on the Medical Staff may be obtained by individual physicians; and
   b. the obligations of Medical Staff membership may be fulfilled.

I.B.2. To serve as the primary means for accountability to the Board of Trustees for the appropriateness of the professional performance and ethical conduct of its members, non-physician professional staff and allied health professionals, and to strive toward the continual upgrading of the quality and efficiency of patient care delivered in the Hospital, consistent with the state of the healing arts and the resources available.

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

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

I.C. RESPONSIBILITIES OF THE MEDICAL STAFF

The responsibilities of the Medical Staff shall be to:

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

   a. An effective mechanism in which the Medical Staff monitors, assumes leadership for and evaluates the quality of patient care and the clinical performance of individuals with delineated clinical privileges, identifies opportunities to improve care, identifies and solves important problems in patient care as a component of the Hospital and the Medical Staff’s quality assessment and improvement process;
   b. An organizational structure and mechanisms that allow ongoing monitoring of patient care practices;
   c. A credentials program, including mechanisms for appointment and reappointment to the Medical Staff, and the matching of clinical privileges to be exercised with the verified
credentials and current demonstrated performance of the applicant, Medical Staff member, non-physician professional staff member or allied health professional;

d. A continuing education program, fashioned at least in part on the needs demonstrated through the quality review, evaluation, and monitoring programs; and

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

I.C.2. Recommend to the Board of Trustees action with respect to appointments, reappointments, staff category and clinical service assignments, clinical privileges, specified services for allied health professionals, and corrective action.

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

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

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

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

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

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

II. MEMBERSHIP

II.A. NATURE OF MEMBERSHIP

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

2. No person shall be entitled to Membership on the Medical Staff, or to be granted or to exercise particular clinical privileges, merely because that person 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 and/or privileges at this or another health care facility.

II.B. QUALIFICATIONS FOR MEMBERSHIP

II.B.1. MINIMUM QUALIFICATIONS

Only physicians shall be deemed to possess basic qualifications for membership in the Medical Staff who:

a. document their current unrestricted licensure in the State of Wyoming;

b. document adequate experience, education, training, and demonstrated competence;

c. agree to adhere strictly to the professional ethics of their respective professions, the American Medical Association Principles of Medical Ethics and the Medical Staff Code of Conduct;

d. demonstrate good reputation and character, including mental and emotional stability and physical health status;

e. agree to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them in the Hospital will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner;

f. agree to abide by the Hospital and Medical Staff Bylaws, rules and regulations, and applicable policies;

g. agree to participate in the discharge of Staff responsibilities as set forth in these Bylaws in general and in particular as set forth in Section II.E.;

h. pledge continuous care to their patients; and

i. comply with such requirements for professional liability insurance coverage as the Medical Executive Committee and the Board shall from time to time adopt.

j. where applicable to their practice, have a current, unrestricted DEA registration and state controlled substance license;

k. are not seeking clinical privileges to treat patients or conditions for which the Hospital lacks necessary equipment, facilities or other resource or for which there is no need based on the Hospital’s strategic plan; and

l. are not seeking clinical privileges that are subject to an exclusive contract except for those individuals approved by the contract holder.

m. Physicians to whom one or more of the following conditions apply, currently or in the past,
are required to report the information on their applications and may be deemed not qualified for Medical Staff membership:

(1) convicted of Medicare, Medicaid, or other governmental or private third-party payer fraud or program abuse, and/or required to pay civil penalties for the same;

(2) excluded, precluded, suspended or restricted from participation in Medicare, Medicaid or other governmental payer programs;

(3) had Medical Staff appointment or clinical privileges denied, revoked, suspended, restricted or terminated by any health care facility or health plan;

(4) resigned or relinquished medical staff appointment or clinical privileges in any health care facility or health plan for reasons related to clinical competence or professional conduct or has withdrawn an application for medical staff membership and/or clinical privileges while under investigation or to avoid an investigation;

(5) had licensure in any state denied, suspended, limited, revoked or terminated, or have withdrawn an application, or resigned licensure, to avoid an investigation, or denial of such application;

(6) convicted of any felony;

(7) convicted of any misdemeanor relating to controlled substances, illegal drugs, insurance fraud or abuse, or violence;

II.B.2. PARTICULAR QUALIFICATIONS

a. An applicant for membership in the Medical Staff must hold an M.D. or D.O. degree issued by a medical or osteopathic school approved at the time of the issuance of such degree by the Wyoming Board of Medicine and must also hold a valid, unrestricted, and unsuspended license to practice medicine issued by the Wyoming Board of Medicine.

b. New applicants applying to the Medical Staff following the adoption of these Bylaws shall have appropriate specialty or sub-specialty certification that is recognized by the American Board of Medical Specialties or Bureau of Osteopathic Specialists or shall have successfully completed an accredited post-graduate training program and be eligible to take the board certification examination in the applicant’s specialty. In the latter case, board certification must be obtained within a two year period of completion of training, unless the physician is required to meet some other requirement prior to being eligible to take the board examination. Failure to qualify for board certification within the allotted time will result in automatic expiration of appointment and clinical privileges. The above board certification requirement may be waived at the discretion of the Medical Executive Committee under the following circumstances:
1) The applicant has successfully completed a residency program of a duration consistent with the requirements of the specialty board in the specialty area in which the applicant is requesting clinical privileges; and

2) The applicant has achieved high professional achievement in his/her discipline as evidenced by fellowship in the American College of Physicians and/or the applicant’s specialty equivalent college; and

3) The applicant has made significant contributions to the scientific literature or as an academic attending or investigator in his/her clinical discipline.

II.B.3. INELIGIBILITY TO APPLY FOR MEDICAL STAFF MEMBERSHIP DUE TO FAILURE TO MEET MINIMAL REQUIREMENTS

An applicant who does not meet the minimum standards described in Section II.B.1. and II.B.2. (except Board-certification or Board-eligibility) is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review. If it is determined during the processing that an applicant does not meet all of the minimum qualifications, the application shall be deemed incomplete and the review of the application shall be discontinued. An applicant who does not meet the minimum qualifications is not entitled to the procedural rights set forth in VIII.B.2.

II.B.4. VIOLATION OF QUALIFICATIONS OF MEMBERSHIP

Violation of the above qualifications of membership shall result in revocation of Membership and/or clinical privileges previously granted.

II.C. BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

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

1. providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital and the physician’s professional association;

2. abiding by the Medical Staff Bylaws and Medical Staff rules and regulations and by applicable rules, regulations or policies approved by the Board of Trustees;

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

4. preparing and completing in timely fashion medical records for all the patients for whom the member provides care in the Hospital;

5. abiding by the lawful ethical principles of the Medical Staff member's applicable professional association, the American Medical Association Principles of Medical Ethics and the Medical Staff Code of Conduct;
6. aiding in any Medical Staff approved educational programs for staff members, nurses and other personnel;

7. working cooperatively with members, nurses, Hospital Administration and others so as to promote high quality patient care;

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

9. refusing to engage in improper inducements for patient referral;

10. participating in continuing education programs as determined by the Medical Staff; and

11. participating in peer review and other quality improvement activities;

12. discharging such other staff obligations as may be lawfully established from time to time by the Medical Executive Committee or the Board of Trustees; and

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

II.D. NONDISCRIMINATION

No aspect of Medical Staff or Non-Physician Professional Staff membership or particular clinical privileges shall be denied on the basis of sex, religion, race, age, creed, color or national origin.

The Medical Staff and Non-Physician Professional Staff application and clinical privileging process shall comply with the Americans with Disabilities (ADA) Act, and, to the extent applicable, the Federal Rehabilitation Act. An applicant for Medical Staff membership or a current Medical Staff member who has disclosed a disability shall not be discriminated against on the basis of such disability. Should the applicant provide information that he or she requires reasonable accommodation to exercise clinical privileges, a careful individualized determination shall be made in each case, as to whether the applicant’s disability poses a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation.
III. CATEGORIES OF MEMBERSHIP

III.A. CATEGORIES

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

III.B. ACTIVE STAFF

III.B.1. QUALIFICATIONS

The active staff shall consist of physician members who:

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

b. attend at least the required total of applicable committee and general Medical Staff meetings each year;

c. have satisfactorily completed their designated term in the provisional staff category; and

d. maintain a full-time practice in Teton County, Wyoming. For purposes of this section, a "full-time practice" shall mean that the physician maintains his or her primary place of medical practice in Teton County, Wyoming. Whether a physician maintains a "full-time practice" in Teton County, Wyoming, for purposes of this section shall be within the discretion, reasonably exercised, of the Medical Executive Committee.

III.B.2. PREROGATIVES

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

a. exercise such clinical privileges as are granted pursuant to Article VI;

b. attend and vote on matters presented at general and special meetings of the Medical Staff and of the committees of which s/he is a member;

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

III.B.3. Active Staff Members granted a sufficient level of clinical privileges to do so may be required to participate in the Emergency Department call schedule in accordance with the following:

a. Any specialty area with more than one Active Medical Staff Member granted clinical privileges shall be required to create and abide by a rotating Emergency Department call schedule, posted in the Emergency Services, providing full-time (twenty-four (24) hours per day, seven (7) days per week, fifty two (52) weeks per year) coverage within that specialty area;
b. Unless the Medical Executive Committee otherwise requests that a member provide call coverage, only active Medical Staff Members who practice in Teton County, Wyoming, on a full-time basis greater than two hundred forty (240) days per year shall be eligible to and required to participate in the Emergency Services call schedule for their specialty, providing an equal proportionate share of such full-time call coverage, except as specifically excluded elsewhere in these Bylaws, or by agreement of all other members of the specialty;

c. A Medical Staff Member who practices on a part-time basis in Teton County, Wyoming, may be required to cover specific call days for an Active Medical Staff Member on the call schedule, as requested by that Medical Staff Member and approved by the Medical Executive Committee; and

d. Inclusion on the Emergency Department call coverage schedule for any particular specialty is an obligation of Active Staff Members granted sufficient clinical privileges. Inclusion on such schedule, or participation in providing medical care to patients coming to the Emergency Department is not a right, benefit or prerogative of any Staff Member, irrespective of the economic or other value to any particular Staff Member or specialty of inclusion on such schedule or participating in Emergency Department call coverage. Any Medical Staff Member may be excused from the obligation of participating in the Emergency Department call schedule at the sole discretion of the Medical Executive Committee. Excusal from such obligation shall not be deemed corrective action, and shall not entitle a Staff Member to any of the notice, hearing or appeal rights set out in these Bylaws, including but not limited to Chapters VII or VIII.

The Medical Executive Committee may, by policy, prescribe further requirements and obligations under this Policy.

III.C. THE COURTESY MEDICAL STAFF

III.C.1. QUALIFICATIONS

The courtesy staff shall consist of physician members who:

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

a. do not maintain the full-time practice requirements set forth in Section III.B.1.e.;

b. are members in good standing of the active Medical Staff of another hospital requiring quality assurance activities of a substance and character similar to those in the Hospital; and

c. have satisfactorily completed their designated term in the provisional staff category;

OR
e. physician members who have attained the age of sixty (60) years plus a minimum of ten (10) years on the St. John’s active Medical Staff or have served on the active Medical Staff of the Hospital for twenty (20) years may elect to go into this Medical Staff category.

III.C.2. PREROGATIVES

Except as otherwise provided, the courtesy staff member shall be entitled to:

a. exercise such clinical privileges as are granted pursuant to Article VI;

b. attend meetings of the Medical Staff, including educational programs;

c. serve on appropriate Medical Staff committees at the discretion of those committees

d. if serving on a Medical Staff committee, vote on committee matters at the discretion of the committee.

III.C.3. LIMITATIONS

a. Courtesy Medical Staff Members who are granted clinical privileges and who exercise such clinical privileges in the Hospital, after review by the Medical Executive Committee, may be asked to seek appointment to the appropriate Staff category.

b. Courtesy staff members have no right to vote at meetings of the entire Medical Staff.

c. Courtesy staff members are not eligible to hold office in the Medical Staff organization.

d. Courtesy staff members are not eligible to vote for Medical Staff officers or representatives to the Medical Executive Committee.

e. Courtesy Medical Staff Members shall not be required to provide Emergency Department call coverage as described in these Bylaws, unless necessary or advisable in the opinion of the Medical Executive Committee, to enable the Hospital to meet its state or federal legal obligations, including but not limited to those under the Emergency Medical Treatment and Active Labor Act (EMTALA).

III.D. CONSULTING STAFF

III.D.1. QUALIFICATIONS

The consulting staff shall consist of physicians who:

a. meet the Medical Staff membership qualifications set forth in Section II.B 1 and 2, with one exception: physicians who regularly provide locum tenens coverage for members of the active Medical Staff may be qualified for consulting staff membership without personally carrying the required level of malpractice insurance coverage. Instead, each time he/she covers for a physician on the active Medical Staff, the covering physician must be insured under the malpractice insurance policy of the physician for whom he/she is covering.
b. provide medical or surgical consultation for Medical Staff Members in other Medical Staff categories, which may include intraoperative consultation.

III.D.2. PREROGATIVES

The consulting staff shall be entitled to:

a. Exercise such clinical privileges as are granted pursuant to Article V; and

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

III.D.3. LIMITATIONS

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

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

   (1) in extraordinary situations where the needs of the Hospital and patient care warrant, admitting privileges may be granted to consulting staff but only upon the recommendation of the Medical Executive Committee;

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

   (3) physicians on the consulting staff who regularly provide locum tenens coverage for members of the active Medical Staff may be granted admitting privileges upon the recommendation of the Medical Executive Committee.

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

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

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

f. Consulting Medical Staff Members shall not be required to provide Emergency Department call coverage as described in these Bylaws, unless necessary or advisable in the opinion of the Medical Executive Committee, to enable the Hospital to meet its state or federal legal
obligations, including but not limited to those under the Emergency Medical Treatment and Active Labor Act (EMTALA).

III.E. PROVISIONAL STAFF

III.E.1. QUALIFICATIONS

The provisional staff shall consist of physicians who:

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

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

III.E.2. PREROGATIVES

The provisional staff member shall:

a. admit patients and exercise such clinical privileges as are granted pursuant to Article VI;

b. be appointed to a specific service;

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

d. vote on matters raised before the Medical Staff committees to which the physician has been appointed.

III.E.3. LIMITATIONS

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

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

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

III.E.4. TERM OF PROVISIONAL STAFF STATUS

Except as provided for in Section II.B.2.b, a member shall remain on the provisional staff for a period of one year, unless that status is extended by the Medical Executive Committee for an additional period of up to one (1) year, on a determination of good cause, which determination shall not give rise to the right to a hearing pursuant to Article VIII.

III.E.5. ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

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

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

III.F. PRECEPTEES

III.F.1. QUALIFICATIONS

Preceptees shall be individuals who:

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

b. are attending clinical rotations at the Hospital; and

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

III.F.2. LIMITATIONS

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

III.G. HONORARY STAFF

III.G.1. QUALIFICATIONS

The honorary staff shall consist of physicians who no longer practice at St. John’s Medical Center but who are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contribution to health and medical sciences, or their previous long-standing service to St. John’s. These individuals shall submit a complete application for Medical Staff membership, which will be subject to the regular credentialing process.

III.G.2. LIMITATIONS

Honorary staff members need not have malpractice insurance. They shall not admit, treat or consult on patients in the hospital. They shall not have any clinical privileges. They may attend appropriate portions of Medical Staff meetings and educational programs. They are not eligible to vote on Medical Staff matters, hold office in the Medical Staff, nor serve on Medical Staff committees.

III.H. LIMITATION OF PREROGATIVES

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

On its own, pursuant to a request by a member under Section V.F.1.b., or at the direction of the Board of Trustees as set forth in Section VII.B.6., the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

IV. NON-PHYSICIAN PROFESSIONAL STAFF AND ALLIED HEALTH PROFESSIONALS

IV.A. NON-PHYSICIAN PROFESSIONAL STAFF

IV.A.1. QUALIFICATIONS

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

a. possess a current unrestricted license;

b. document adequate experience, education, and training;

c. demonstrate current professional competence;

d. demonstrate good judgment;

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

f. are determined that they will:

(1) adhere to the ethics of their respective professions;

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

(3) agree to function in an orderly manner;

(4) be willing to participate in and properly discharge those responsibilities determined by the Medical Staff and Board of Trustees; and
g. comply with such requirements for professional liability insurance coverage as the Medical Executive Committee and the Board of Trustees shall from time to time adopt;

IV.A.2. PARTICULAR QUALIFICATIONS

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

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

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

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

IV.A.3. PREROGATIVES

a. Non-physician professional staff:

(1) may treat patients and utilize hospital services, exercising independent judgment in the area of their expertise and competence, and may exercise clinical privileges granted in the management of patients, in conjunction with a Medical Staff member eligible to care for such patients;

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

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

b. Psychologists shall be members of the Psychology Committee with full voting privileges at those committee meetings and shall meet attendance requirements as outlined in sections XII.D. of these bylaws.

c. Non-physician professional staff may be appointed by the Chief of Staff to other Medical Staff committees.
IV.A.4. LIMITATIONS

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

b. Non-physician professional staff shall hold no admitting privileges at the Hospital except as outlined in section IV.A.4.c.

c. A non-physician professional staff member or applicant may petition the Medical Executive Committee on an individual basis for admitting privileges if s/he can provide adequate documentation of her/his training, experience, and competency to admit and care for patients independently throughout the hospital stay.

d. Non-physician professional staff are not eligible to vote for Medical Staff officers or representatives to the Medical Executive Committee.

IV.A.5. RESPONSIBILITIES

As a condition of applying for, or being granted, status as a non-physician professional staff member and practice prerogatives, each applicant agrees that s/he shall:

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

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

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

d. serve on the committees to which the member has been appointed by the Chief of Staff;

e. attend and document attendance at educational programs in his or her field of practice; St. John’s accepts the continuing education requirements of the entity which licenses the practitioner;

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

g. maintain the confidentiality of all peer review related matters and waive any right he/she may have under State law to disclose such matters.
IV.B. ALLIED HEALTH PROFESSIONALS

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

IV.B.1. CATEGORIES OF AHPs ELIGIBLE FOR PRACTICE PREROGATIVES

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

IV.B.2. QUALIFICATIONS

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

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

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

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

   d. Maintain professional liability insurance as required by these Bylaws, Rules and Regulations.
IV.B.3. PROCEDURE FOR GRANTING PRACTICE PREROGATIVES

a. Each AHP must apply and qualify for practice prerogatives by submitting an application on the approved form, providing all necessary information, and agreeing to be bound by the applicable Bylaws, rules and regulations of the Medical Staff and Hospital policies. Applications for initial practice prerogatives, and biannual renewal thereof, shall be submitted and processed in accordance with the procedures stated in Article V of these Bylaws.

b. Each AHP who is granted practice prerogatives shall be allowed to participate in the clinical service appropriate to the AHPs occupational or professional training and shall be assigned a supervising physician on the Medical Staff, if appropriate. Unless otherwise specified in these Bylaws or the Rules and Regulations, AHPs shall be subject to terms and conditions paralleling those in Article V of these bylaws as they apply to the more limited practice of AHPs.

IV.B.4. LIMITATIONS

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

b. AHPs shall hold no admitting privileges at the Hospital.

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

d. AHPs are not entitled to the hearing and appeal rights under these Bylaws.

IV.B.5. RESPONSIBILITIES

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

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

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

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

d. Serve on Medical Staff, service and Hospital committees to which the AHP is requested by the service chief or Chief of Staff;
e. Attend the meetings of the relevant service, as permitted by the service rules and regulations;

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

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

h. Maintain the confidentiality of all peer review related matters and waive any right s/he may have under State law to disclose such matters.

IV.C. TERMINATION OF PRACTICE PREROGATIVES

1. An AHP’s or non-physician professional staff member’s practice prerogatives shall terminate automatically at the sole discretion of the Chief of Service to which the member has been assigned, upon the occurrence of any of the following:
   a. conduct by the member which interferes with or is detrimental to the provision of quality patient care; or
   b. failure of the AHP to perform properly assigned duties.

2. An AHP’s or non-physician professional staff member’s practice prerogatives shall terminate automatically at the sole discretion of the Chief Executive Officer upon the occurrence of any of the following:
   a. suspension, revocation, expiration, voluntary or involuntary restriction, termination, or imposition of terms of probation by the applicable licensing or certifying agency of the member’s license, certificate or other legal credential which authorizes the member to provide health care services;
   b. termination of the Medical Staff membership of any supervising or collaborating physician if applicable;
   c. termination of the relationship between the AHP and any supervising or collaborating physician if applicable;
   d. failure of the member to maintain required professional liability insurance;
   e. failure of any supervising or collaborating physician to maintain active Medical Staff membership or clinical privileges in good standing if applicable; or
   f. termination of the supervising or collaborating physician’s contract or other relationship with the Hospital for any reason if applicable.
IV.D. LIMITATION OF PREROGATIVES

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

IV.E. GRIEVANCE PROCESS

Nothing contained in these Bylaws shall be interpreted to entitle a member of the AHP staff to the hearing and appeal rights set forth in these Bylaws, unless otherwise required by law. However, a member of the Non-physician professional staff or an AHP may challenge any action by filing a written grievance, within fifteen (15) days of the adverse recommendation or action, with the chief of the service to which the Non-physician professional staff member or AHP has been assigned. Upon receipt of the grievance, the chief of service shall initiate an investigation and afford the Non-physician professional staff member or the AHP an opportunity for an interview. The chief of service may appoint a committee to conduct the interview. The interview shall not constitute a "hearing" as described in these Bylaws, and shall not be conducted according to the procedural rules applicable with respect to such hearings. Before the interview, the Non-physician professional staff member or AHP shall be informed of the general nature of the circumstances giving rise to the action. The affected Non-physician professional staff member or AHP may present relevant information at the interview. If the recommendation of the chief of service is to terminate the individual's practice prerogatives, the matter shall be referred to the Medical Executive Committee. For AHPs, an adverse recommendation shall be forwarded to the Board of Trustees for final action without the right to a hearing or appeal. For Non-physician professional staff members, if the Medical Executive Committee recommends termination of practice prerogatives, this recommendation shall trigger a right to the hearing and appeal process as set forth in these bylaws.

V. CLINICAL PRIVILEGES

V.A.1 EXERCISE OF PRIVILEGES

Except as otherwise specified herein, no person (including persons engaged by the Hospital in medico-administrative positions) shall admit or provide medical care, treatment or health-related services to patients in the Hospital unless and until that person applies for and receives a grant of clinical privileges sufficient to do so. Except as otherwise provided in Sections V.D. and V.E., a Staff member shall be entitled to exercise only those clinical privileges at the Hospital specifically granted to him or her by the Board. Said clinical privileges must be Hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in Wyoming and consistent with any restrictions thereon, and shall be granted and exercised subject to these Bylaws, and any applicable rules and regulations, policies and procedures, of the Medical Staff, as well as any applicable Service rules and regulations.
V.A.2 EVALUATION UPON GRANT OF CLINICAL PRIVILEGES

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

V.B. DELINEATION OF PRIVILEGES IN GENERAL

V.B.1 REQUESTS

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

V.B.2 A Staff member who seeks modification of clinical privilege(s) previously granted may submit such a request at any time on a form developed by the Medical Executive Committee, except that such applications for additional privileges may not be filed within six (6) months of the time a similar request has been denied. The request must be accompanied by an acceptable statement of the basis for the request and data supporting the request, including documentation of appropriate training and experience.

V.B.3 BASIS FOR DETERMINATION OF PRIVILEGES

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

V.B.4 Ongoing Professional Practice Evaluation.

a. All Medical Staff Members granted clinical privileges (other than the privilege to refer and follow patients) shall be subject to ongoing professional practice evaluation during the Member’s term of appointment, in accordance with such policies as may approved from time to time by the Medical Executive Committee.
b. The Medical Executive Committee, by policy, determine a minimum number of patient encounters a Staff Member must perform within a given period required for Staff Members to qualify to undergo ongoing professional practice evaluation. If any Staff Member fails to meet the required minimum number of patient encounters in the time period prescribed, he or she may be determined to lack sufficient data on which to perform an ongoing professional practice evaluation, and such Member shall be deemed to have voluntarily resigned all clinical privileges other than “refer and follow”, or may be ineligible to be reappointed to the Medical Staff or to have his or her clinical privileges renewed.

V.C. TEMPORARY CLINICAL PRIVILEGES

V.C.1. CIRCUMSTANCES

a. Temporary clinical privileges may be granted to a new applicant to meet an important patient care need, provided the applicant has clinical privileges at another hospital and the procedure described in Section V.C.2 has been followed.

b. Temporary clinical privileges may be granted to a preceptor from another organization, for the purpose of providing specific training to one or more members of the St. John’s Medical Staff relevant to a new procedure or technique, new equipment or instrument, or other training needs.

c. Temporary clinical privileges may be granted to a proctor from another organization for the purpose of supervising a member of the St. John’s Medical Staff as required by the Medical Executive Committee or as otherwise appropriate.

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

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

f. Locum Tenens

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

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Approved by Board of Trustees: January 28, 2015
The locum tenens practitioner will be expected to complete all required medical record documentation prior to his/her departure from the Hospital. Failure to do so may result in denial of a future request for privileges at the Hospital. That notwithstanding, ultimately it is the responsibility of the physician for whom the locums physician is covering to ensure that the required medical record documentation is completed within the specific timeframes outlined in Medical Staff rules, regulations and policies. Failure to obtain the required documentation from the locums physician or to complete the required documentation will result in automatic suspension (for medical record delinquency) of the physician for whom the locums physician was covering.

V.C.2. APPLICATION AND REVIEW

a. On receipt of a completed application and supporting documentation from a practitioner authorized to practice in Wyoming, the Chief of Staff or Medical Executive Committee designee and Chief Executive Officer or his/her designee may grant temporary privileges to an applicant who appears to have qualifications, ability, and judgment, consistent with Sections II.B.1.-2. and IV.A.1., but only after:

(1) verification of the following:
   • current licensure
   • relevant training or experience
   • current competence
   • ability to perform the privileges requested
   • a query and evaluation of the NPDB information
   • a complete application
   • no current or previously successful challenge to licensure or registration
   • no subjection to involuntary termination of Medical Staff membership at another organization
   • no subjection to involuntary limitation, reduction, denial or loss of clinical privileges
   • current DEA registration (if applicable)
   • current professional liability insurance in the required amount
   • obtain a criminal background check

(2) the applicant's file has been forwarded for peer review to an appropriate practitioner (e.g., chief of service or specialty representative to the Medical Executive Committee or physician of the same specialty which is not represented on the Medical Executive Committee or Psychology Committee Chair).

(3) the above reviewer has interviewed the applicant and has contacted at least two people who:
   a) have recently worked with the applicant;
   b) have directly observed the applicant's professional performance over a reasonable time;
(c) provide reliable information regarding the applicant's current professional competence, ethical character, and ability to work well with others so as to promote high quality patient care; and

(4) the above reviewer has reviewed the applicant's file and has recommended approval of temporary privileges.

V.C.3. GENERAL CONDITIONS

a. If granted temporary privileges, the applicant shall act under the supervision of the chief of service, and shall ensure that the chief of service is kept closely informed as to his or her activities within the Hospital.

b. Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the Medical Executive Committee, or unless affirmatively renewed following the procedure as set forth in Section VI.

c. Requirements for proctoring and monitoring shall be imposed on such terms as may be appropriate under the circumstances on any member granted temporary privileges by the Chief of Staff.

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

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

f. All persons requesting or receiving temporary privileges shall be bound by the Bylaws and rules and regulations of the Medical Staff.

V.D. EMERGENCY PRIVILEGES

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

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Approved by Board of Trustees: January 28, 2015
V.E. DISASTER PRIVILEGES

The Hospital may grant clinical privileges without following the process described in Section VI.B or VI.C, to licensed physicians and other licensed independent practitioners only when the Hospital’s emergency operations plan has been activated in response to a disaster, as defined herein, and the Hospital is unable to meet immediate patient care needs with Hospital Staff Members. During such disaster, every Staff Member may be deemed “temporarily privileged”, as set out below, to provide any type of patient care necessary as a life-saving measure or to prevent serious harm, regardless of his/her current clinical privileges, so long as the care provided is within the scope of the individual’s current license. Such temporary privileges (“disaster privileges”) may likewise be granted by the Chief of Staff or the Chief Executive Officer or their designees upon to any licensed physician or other licensed independent practitioner (collectively, such Staff Members and licensed independent practitioners are referred to as “disaster practitioners”) upon presentation of appropriate identification as outlined in the appropriate Medical Staff policy. The decision to grant disaster privileges will be made on a case-by-case basis, based upon then-present patient care needs and in the sole discretion of the Chief of Staff and/or the Chief Executive Officer, who will assign the disaster practitioner to provide services in a clinical area of the Hospital. The professional performance of each disaster practitioner will be overseen by a Medical Staff Member in charge of the specific assigned clinical areas. As soon as the disaster is under control and the Chief Executive Officer determines that the Hospital’s patient care needs can be met without disaster practitioners, the Medical Staff Coordinator will initiate the credentials verification and privileging process, as necessary, for those disaster practitioners who have been granted disaster privileges. The primary source credentials verification process, as described in these Bylaws and appropriate Medical Staff Rules and policies, shall be completed within 72 hours from the time the Staff Member or volunteer practitioner presents to the Hospital and requests disaster privileges. If this is not possible due to extraordinary circumstances, the process will be done as soon as possible and the Hospital will ensure that it appropriately documents such circumstances, its credentialing efforts, and the disaster practitioner’s demonstrated ability to continue to provide adequate care, treatment and services. Based on information regarding the disaster practitioner’s professional practice, obtained from those Medical Staff Members overseeing the disaster practitioner’s clinical area, the Hospital will decide within 72 hours whether to continue the disaster privileges initially assigned. Primary source verification is not required if the disaster practitioner has not provided care, treatment or services using the disaster privileges. For purposes of this section, a “disaster” is an emergency that, due to its complexity, scope or duration, threatens the organization’s capabilities and requires outside assistance to sustain patient care, safety or security.

VI. STAFF APPOINTMENT AND CLINICAL PRIVILEGES PROCESS

VI.A. GENERAL

V.A.1. AUTHORITY

Appointment to the Medical Staff, the Non-Physician Professional Staff or the AHP staff shall confer on the appointee a privilege in the nature of a license to exercise only such clinical privileges as have been specifically granted in accordance with these Bylaws. An appointee is neither an
employee nor an independent contractor of the Hospital, unless such a relationship is separately established between the Hospital and the appointee.

VI.A.2. LIMITATIONS ON MEMBERSHIPS IN SERVICES

Upon recommendation by the Medical Executive Committee, the Board shall have the authority to limit the number of appointees within particular subspecialties, services, or particular categories of the Staff, including the Medical Staff, by establishing numerical limitations on the admission of applicants to such specialty, service or category of the Staff. Numerical limitations shall be initiated and applied only to the extent consistent with Wyo. Stat. § 35-2-113, and shall be reasonable in light of the needs of the Hospital’s community. The numerical limitation for any subspecialty or service (i) shall be reviewed on a periodic basis, but at least every two (2) years, by the Chief Executive Officer and the chief of the applicable service, and (ii) may be raised, lowered, or rescinded by the Chief Executive Officer after consultation with the chief of the applicable service and concurrence by the Chief of Staff and the Medical Executive Committee and with approval by the Board of Trustees. Applications from Practitioners for Staff membership in a sub-specialty, service or category that has reached its limit shall not be accepted for consideration, and such declination to consider the application shall not be considered a “denial” within the meaning of these Bylaws.

VI.B. BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement or transfer to the Staff, or applications for initial grant(s) or continuation or renewals of clinical privileges, the applicant shall have the burden of (a) producing all information reasonably necessary for an adequate evaluation of the applicant’s qualifications and suitability for Staff category and/or clinical privileges requested, (b) resolving any reasonable doubts about these matters, and (c) satisfying requests for information. The applicant's failure to sustain this burden, or falsification or misrepresentation of any information in any such application shall be grounds to deny the application or to deem the application incomplete. Satisfaction of this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which may select the examining physician and which shall be done in accordance with Section II.D., if applicable.

VI.C. APPOINTMENT AUTHORITY

Appointments, denials, revocations, suspensions, and restrictions of Staff appointments and/or clinical privileges shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Executive Committee, or as set forth in Section VII.

VI.D. DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments to the Staff, and/or grants of clinical privileges, shall be for a period of one (1) year. Reappointments to the Staff, and/or renewal or continuation of clinical privileges, shall be for a period of up to two (2) Medical Staff years, and shall expire on the Member’s date of appointment of every other year.
VI.E. APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT TO THE STAFF

The basic steps of the process of application for initial appointment, and reappointment, to the Staff are described in these Bylaws. The Medical Executive Committee may, by policy, describe and create associated details, including additional steps in such processes, to the extent not inconsistent with the basic steps described herein.

VI.E.1. PRE-APPLICATION

The Medical Staff may require each practitioner to submit a pre-application form, developed, maintained and revised from time to time by the Medical Executive Committee through policy, indicating that s/he satisfies the minimum qualifications for Medical Staff membership as set forth in Section II.B.1, as a pre-requisite to submitting an application for Staff membership and/or grant of clinical privileges.

VI.E.2. APPLICATION FORM

The Medical Staff shall be responsible for creating, maintaining and revising as appropriate an application form for initial appointment and reappointment to the Staff and/or grant of clinical privileges, which, as currently existing and as may be revised from time to time, may be incorporated into a policy of the Medical Staff. The application shall require submission of sufficient information regarding the following to allow the Medical Staff to grant Staff membership in the category and/or any clinical privileges requested:

a. current licensure;

b. education and relevant training;

c. experience, ability and current competence to discharge the applicable obligations of Staff membership and/or exercise the clinical privileges requested;

The Medical Executive Committee shall determine in its sole discretion the types, amount and sources of information necessary or advisable required to be submitted as part of any such application.

VI.E.3. The application shall require the practitioner to:

a. authorize the Hospital’s consultation with others who have been associated with the applicant and who may have information bearing on the applicant’s licensure, education, training, experience, ability and competence to discharge the obligations and prerogatives of Staff Membership and/or clinical privileges applied for, and authorize such individuals and organizations to candidly provide all such information requested by Hospital, including otherwise privileged or confidential information;

b. agree that any information so provided may not be required to be disclosed to him or her;

c. agree and authorize Hospital all such information received by Hospital, or created by Hospital during the term of practitioner’s Staff Membership, to disclose to other hospitals,
medical associations, licensing boards, and to other similar organizations as requested by such organizations, and permitted or required by law, and

VI.E.4 The contents of the application(s) described in Section VI.E.2 and 3 are intended as general descriptions. The application(s) may expand the foregoing, or add other contents, to the extent not inconsistent with these Bylaws, and/or contain other agreements, understandings, covenants, waivers, authorizations, or releases, provided or authorized by law.

VI.E.5. IMMUNITY FROM LIABILITY

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

a. the Hospital, the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges, or the individual’s qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, the Medical Staff, authorized agents, or appropriate third parties.

b. any third party for releasing or disclosing information, including otherwise privileged or confidential information, to any Hospital representative concerning any former or current applicant or Medical Staff appointee unless such information is false and the third party providing it knew it was false.

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

- applications for appointment and/or clinical privileges;
- periodic reappraisals undertaken for reappointment or for changes in clinical privileges;
- corrective action;
- hearings and appellate reviews;
- patient care audits;
- medical care evaluations;
- utilization reviews;
- other Hospital, Staff, service, committee, and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct;
- matters or inquiries concerning the credentials of any applicant or Medical Staff appointee;
- matters directly or indirectly affecting patient care or the efficient operation of the Hospital; and
- reports to the National Practitioner Data Bank established pursuant to the Act.
VI.E.6. VERIFICATION OF INFORMATION/ CREDENTIALS REVIEW

The applicant shall deliver a completed application, including any required dues or fees, to the Medical Staff Office, whereupon the Medical Staff Office staff will verify all information through primary sources. The Medical Staff Office will then request a peer of the same specialty to review the application and make a separate recommendation for appointment and/or clinical privileges to the Credentials Committee. Each applicant’s application will be reviewed by the Credentials Committee, which will make a recommendation on the practitioner’s application for Staff appointment and a separate recommendation, on the practitioner’s application for clinical privileges, if any, to the Medical Executive Committee. Each new Active Medical Staff applicant shall be interviewed by the Credentials Committee or their designee(s) prior to the Credentials Committee making its recommendation(s) to the Medical Executive Committee regarding the application.

VI.E.7. MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee shall consider the practitioner’s application for Staff appointment and for clinical privileges (if any) separately, along with any other relevant information. The Medical Executive Committee may request additional information, initiate further investigation, and/or elect to interview the applicant. The Medical Executive Committee may also defer action on the application for a reasonable period of time, not to exceed ninety (90) days. The reasons for deferral shall be stated generally. If not deferred, the Medical Executive Committee shall make a recommendation on the practitioner’s application for Staff appointment, and a separate recommendation on the practitioner’s application for clinical privileges, if any.

VI.E.8. EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

a. Favorable Recommendation: When the Medical Executive Committee makes a recommendation favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Joint Conference Committee for consideration and recommendation. The Joint Conference Committee’s recommendation shall be forwarded with the Medical Executive Committee’s recommendation to the Board of Trustees.

b. Adverse Recommendation: When the Medical Executive Committee makes a recommendation adverse to the applicant the Medical Executive Committee shall notify the applicant of the adverse recommendation, and, if applicable, the applicant shall be entitled to a hearing and appeal, as set out in these Bylaws.

VI.E.9. ACTION BY BOARD OF TRUSTEES

Promptly following its receipt of the Medical Executive Committee's favorable recommendation, and Joint Conference Committee’s recommendation, regarding an application for Staff appointment and/or clinical privileges, the Board of Trustees, or a subcommittee thereof, shall review and consider the Medical Executive Committee’s recommendation together with the application and related information, and make its recommendation. As part of its review, the Board of Trustees may conduct whatever investigation it deems necessary relating to the
application. If the Board of Trustee’s recommendation is favorable to the applicant, it shall be deemed final action. If the recommendation of the Board of Trustees is adverse to the applicant, the applicant shall be notified of the general reasons why the adverse recommendation was made, and, if applicable, his or her right to request a hearing pursuant Section VII and/or Section VIII.

VI.E.10. APPOINTMENT RECOMMENDATIONS

Each favorable recommendation made during the Medical Staff appointment and/or clinical privileging processes shall specify the membership category, service affiliation, and/or clinical privileges to be granted, and any special conditions to be attached to the Staff membership and/or clinical privileges and the general reasons for such condition.

VI.E.11. REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding Staff appointment shall not be eligible to reapply for appointment for a period of five (5) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

VI.E.12 TIMELY PROCESSING OF APPLICATIONS

Applications that are, and remain, complete shall be processed within 120 days of being deemed complete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period. Whenever the Chief of Staff and Chief Executive Officer agree that the review process has been unduly delayed at any particular step, they may jointly direct the review to be advanced to the next applicable step.

VI.F. REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS

The basic steps of the process for Staff Members to be reappointed to the Staff and/or for renewal of clinical privileges, are described in these Bylaws. The Medical Executive Committee may, by policy, describe and create associated details, including additional steps in such processes, to the extent not inconsistent with these basic steps.

VI.F.1. APPLICATION

a. Before a Member’s staff appointment and/or clinical privileges expire, an application for reappointment and/or renewal, in a form approved by the Medical Executive Committee and the Board of Trustees, shall be made available to the Member. The Member shall be solely responsible for completing such application form and submit the completed application to be considered for continuation of Staff Membership at least sixty (60) days prior to the Member’s expiration date. Medical Staff Members shall be required to have completed at least 60 hours of “category one” (as defined by the American Medical Association) continuing medical education in their specialty in the past two (2) years to be eligible for renewal of clinical privileges. Upon receipt of the application, the information shall be processed as set forth at Section VI.E.6.
b. A Staff Member who seeks a change in Staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the Medical Executive Committee, except that such application may not be filed within one (1) year of the time a similar request has been denied.

VI.F.3. STANDARDS AND PROCEDURE FOR REVIEW

When a Staff member submits the first application for reappointment or renewal of staff membership and/or clinical privileges, and every two (2) years thereafter, or when Medical Staff member submits an application for modification of membership statues and/or clinical privileges shall be subject to an in-depth review, generally following the procedures set forth in Sections V.E.6. through V.E.11.

VI.F.4. FAILURE TO COMPLETE REAPPOINTMENT APPLICATION PROCESS

If an application for reappointment of Staff membership and/or clinical privileges has not been fully processed by the expiration date of the Member's appointment and/or grant of privileges, the Staff Member may be appointed to the locum tenens staff (if a Medical Staff member) and/or granted temporary clinical privileges according to Section V.D.1 of these Bylaws, and thereby maintain membership status and clinical privileges until such time as the processing is completed. This option shall not be available if the delay is due to the Member's failure to timely complete and return the application form or provide other documentation or cooperation, in which case the appointment and/or grant shall expire at the end of the then current term. Any such appointment and/or grant does not create a vested right in the Member for continued appointment and/or clinical privileges through the entire next term but only until such time as processing of the application is concluded.

VI.F.5. FAILURE TO SUBMIT APPLICATION

Failure to timely file a completed application for reappointment shall result in the expiration of the Member’s appointment and/or clinical privileges at the end of the then current term, unless locum tenens Staff membership and/or temporary clinical privileges are granted according to these Bylaws, or as set out in a policy approved by the Medical Executive Committee. In the event membership and/or clinical privileges expires for the reasons set forth herein, the Staff Member shall not be entitled to a hearing or appeal under Section VIII, or to avail themselves of the Grievance Process, set out in Section IV.E, if applicable.

VI.G. LEAVE OF ABSENCE

VI.G.1. LEAVE STATUS

At the discretion of the Medical Executive Committee, a Member may request a voluntary leave of absence from the Staff by submitting a written request to the Medical Executive Committee stating:

a. the approximate period of leave desired, which may not exceed twelve (12) consecutive months or the end of the Member’s current appointment period, whichever is sooner;
b. a description of the benefits the Medical Staff member expects to gain by taking the leave of absence, and the benefits to the Medical Staff of the Member being granted a leave of absence;

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

d. sufficient information for the Medical Executive Committee to determine that the leave of absence, as opposed to the Member resigning his or her Medical Staff membership and/or clinical privileges, is justified; and

e. sufficient information so that the Hospital can determine whether a statement under Section VI.G.4 is required if the Member returns.

During the period of the leave, the Member shall not exercise clinical privileges at the Hospital nor be subject to OPPE, nor be entitled to exercise any of the rights or fulfill any of the responsibilities or obligations of Membership, including the obligation to maintain professional liability insurance. The obligation to pay dues, if any, shall continue, unless waived by the Medical Executive Committee.

VI.G.2 If a Medical Staff Member on leave fails to timely submit an application for continuation of his or her Medical Staff Membership, as described above, his or her Medical Staff Membership shall expire.

VI.G.3. TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Member shall notify the Medical Executive Committee in writing of the date his or her leave will terminate, and that he or she will return from the leave of absence. The Staff Member shall submit a summary of relevant activities during the leave and warrant that all conditions imposed by the Medical Executive Committee on the Member for the leave have been fulfilled. The Medical Executive Committee may upon receipt of the notice require the Member to submit to an interview, and may decline to accept the notification if it determines that the Member has not satisfied all conditions required for return. Upon termination of leave of absence, the Member may be subject to FPPE, proctoring, co-management or other such observation or supervision as the Medical Executive Committee shall, in its discretion, determines is necessary to ensure patient safety, before the Member resumes the exercise of any clinical privileges. Such observation and/or supervision measures shall not be in effect for more than twenty nine (29) days unless the Member is entitled to such hearing and appeal rights as are described in these Bylaws.

VI.G.4 FAILURE TO REQUEST REINSTATEMENT

Failure to notify the Medical Executive Committee of termination of a leave of absence shall be deemed a voluntary resignation and shall result in expiration of Staff membership. A member whose Staff Membership expires or is deemed to have voluntarily resigned shall not be entitled to

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the hearing and/or appeal rights set out in Section VIII, nor the grievance process set out in Section IV.E. Except as set out in a policy approved by the Medical Executive Committee, a request for continuation of or reappointment to membership subsequently received from a former member whose membership has expired or has been deemed to have voluntarily resigned, shall be submitted and processed in the manner specified for applications for initial appointments, except that the application fee shall be waived.

VI.G.5. REINSTATEMENT AFTER LEAVE FOR REASONS OF HEALTH OR DISABILITY

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

VII. CORRECTIVE ACTION

VII.A. ROUTINE MONITORING AND EDUCATION

VII.A.1. RESPONSIBILITY

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

VII.A.2. PROCEDURE

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

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

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

d. Reporting to Medical Executive Committee: Actions taken pursuant to Section VII.A.2.b. need not be reported to the Medical Executive Committee. Actions taken pursuant to Section VII.A.2.c. shall be reported to the Medical Executive Committee promptly after such actions are taken. Such actions taken pursuant to Subsection VII.A.2.c. shall be documented in the member's credentials file.

VII.B. CORRECTIVE ACTION

VII.B.1. CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of staff members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) unethical; (3) contrary to the Medical Staff or Hospital Bylaws, Rules and Regulations, or Policies; or (4) below applicable Medical Staff or Hospital professional standards, a request for an investigation or action against such member may be initiated by the Chief of Staff, the Chief Executive Officer or the Medical Executive Committee.

VII.B.2. INITIATION

A request for an investigation must be in writing, submitted to the Medical Executive Committee and the Chief Executive Officer, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee or the Chief Executive Officer initiates the request, the reasons shall be recorded. The member shall be notified in writing of the allegations and the fact that there has been a request for investigation.

VII.B.3. INVESTIGATION

If the Medical Executive Committee or the Chief Executive Officer concludes that an investigation is warranted, the Medical Executive Committee shall direct an investigation to be undertaken and shall assign the task to an appropriate Medical Staff officer, committee of the Medical Staff or one or more Medical Staff members who shall not have been substantially involved in the matter in

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question. If the Chief Executive Officer concludes that an investigation is warranted, but the Medical Executive Committee does not, the Board of Trustees may initiate corrective action, as set forth in Article VII.B.6. hereof. The Medical Executive Committee in its discretion may appoint physicians, dentists, podiatrists, chiropractors or psychologists who are not members of the Medical Staff and who have not been substantially involved in the matter in question as temporary members of the Medical Staff for the sole purpose of serving on a standing or ad hoc committee, should circumstances warrant. An outside consultant or agency may be used to conduct the investigation for reasons which include but are not limited to the following:

a. the clinical expertise needed to conduct the review is not available on the Medical Staff; or

b. the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

c. the individuals with the necessary clinical expertise would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

If the investigation is delegated to an officer, body or individual(s) other than the Medical Executive Committee, such officer, body or individual(s) shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee. The officer, body, individual(s) or committee conducting the investigation shall make a reasonable effort to complete the investigation and issue its report within 30 days of the request for investigation being issued. When an outside review is necessary, the officer, body, individual(s) or committee investigating the matter shall make a reasonable effort to complete the investigation and issue its report within 60 to 90 days of receiving the request for an investigation. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating entity is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

The report of the investigating entity may include recommendations for appropriate corrective action.

The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating individual(s) or body deems appropriate. The individual or body investigating the matter may, but is not obligated to, review relevant documents and/or conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VIII, nor shall procedural rules with respect to hearings apply. In such an interview, the member shall not be entitled to representation by an attorney, but s/he may be accompanied by another Staff member. Despite the status of any investigation, at all times the Medical Executive Committee shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, corrective counseling, issuance of a letter of warning, admonition, or reprimand (which letter would become part of the member’s Quality Assurance file), or other action.
VII.B.4. MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall issue a written invitation to the involved practitioner to meet with the Medical Executive Committee to discuss the corrective action matter. The practitioner will be asked to respond in writing to the invitation. Following the meeting with the practitioner, the Medical Executive Committee shall take action, which may include, without limitation:

a. determining no corrective action be taken;

b. deferring action for a reasonable time, not to exceed ninety (90) days, where circumstances warrant;

c. issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Medical Staff officers from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's credentials file;

d. recommending the imposition of terms of probation or special limitation upon continued membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

e. recommending reduction, modification, suspension or revocation of clinical privileges;

f. recommending reduction of membership status;

g. recommending suspension, revocation or probation of membership; and

h. taking other actions deemed appropriate under the circumstances.

VII.B.5. SUBSEQUENT ACTION

a. If corrective action as set forth in Section VIII.B.1. is recommended by the Medical Executive Committee, the Medical Executive Committee shall give the physician written notice of its recommendation as provided in Section VIII.C.1. A copy of that notice shall be sent to the Board of Trustees for information only. Unless the Medical Executive Committee has decided to impose a summary suspension, the Medical Executive Committee's recommended action shall not go into effect until the physician has either completed or waived any applicable hearing rights provided in Article VIII. Any Medical Executive Committee action which has become effective shall remain in effect until it expires according to its own terms or is modified or terminated by the Medical Executive Committee or the Board of Trustees.

b. If the Medical Executive Committee does not recommend any corrective action which would entitle the physician to a hearing as specified in Section VIII.B., the Medical Executive Committee shall transmit its recommendation, together with a report of its investigation, to
the individual or committee to whom the Board of Trustees has delegated authority to make initial recommendations for corrective action. That individual or committee may adopt the Medical Executive Committee’s recommendation (in which case the recommendation shall become final). The individual or committee may also elect to remand the matter to the Medical Executive Committee for further review and recommendation, to investigate the matter further or to recommend different corrective action, provided that individual or committee shall consider the Medical Executive Committee recommendation.

VII.B.6. INITIATION BY BOARD OF TRUSTEES

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Trustees may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. If the Medical Executive Committee fails to take action in response to the Board of Trustees' direction, the Board of Trustees may initiate corrective action, but in such event, the Board of Trustees and the practitioner must comply with the provisions of Articles VII and VIII of these Bylaws.

VII.C. PRECAUTIONARY RESTRICTION OR SUSPENSION

VII.C.1. CRITERIA FOR INITIATION

Whenever there are reasonable grounds to believe that the conduct or activities of a member pose a threat to the life, health, or safety of any patient, employee, or other person present at the Hospital and that the failure to take prompt action may result in imminent danger to the life, health or safety of any such person, as determined by concurrent or retrospective evaluation, the Chief Executive Officer, Chief of Staff, or the Medical Executive Committee may summarily restrict or suspend the Medical Staff membership or clinical privileges of such member. A precautionary suspension is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension. Such precautionary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly (within no more than five (5) days) give written notice to the Board of Trustees, the Medical Executive Committee, the member, and the Chief Executive Officer. The Medical Executive Committee may then recommend such further corrective action as may be appropriate, based upon information disclosed or otherwise made available to it and/or it may direct that an investigation be undertaken pursuant to Section VII.B.3. The precautionary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the precautionary restriction or suspension, the member’s patients shall 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 physician, dentist, podiatrist, chiropractor or psychologist. The notice of the precautionary suspension given to the Medical Executive Committee shall constitute a request for corrective action, and the procedures set forth in this Article VII shall be followed. The corrective action investigation should be completed promptly.

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VII.C.2. MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee may modify, continue or terminate any precautionary suspension imposed. In all instances, the member shall be notified of the decision of the Medical Executive Committee.

VII.D AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member’s privileges or membership may be automatically suspended, and a hearing, if permitted and requested, shall be limited to the question of whether the grounds for automatic suspension have occurred.

VII.D.1 LICENSURE

a. Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, membership and clinical privileges shall 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, any clinical privileges which the member has been granted at the Hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout at least the term of the restriction.

c. Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation, as of the date such action becomes effective and throughout at least the term of the probation.

b. Notification: Whenever a member fails to report to the Hospital any restriction or condition imposed on or probation with respect to his or her license within thirty (30) days of the imposition of such restriction, condition or probation, clinical privileges shall be automatically revoked as of the date that the Hospital learns of such failure.

VII.D.2 DRUG ENFORCEMENT ADMINISTRATION (DEA) CONTROLLED SUBSTANCE CERTIFICATE

a. Whenever a member's DEA certificate is revoked, limited, suspended, or expired, the member shall 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 at least the term of the revocation, limitation, or suspension.

b. Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout at least the term of the probation.
VII.D.3 CONVICTION OF FELONY

A member who is convicted of a felony shall immediately and automatically be suspended from practicing in the Hospital if the Medical Executive Committee decides that the felony conviction has a substantial relationship to the qualifications, functions or duties of the Staff member.

VII.D.4 REPEATED SUBSTANTIATED REPORTS OF CODE OF CONDUCT VIOLATIONS

All Practitioners are required to abide by the Medical Staff’s Bylaws, Rules and Regulations, and Policies, including the Code of Conduct. Repeated, frequent reports of a Practitioner violating the Code of Conduct are reasonable cause to question whether the Practitioner satisfies the minimum requirements of Medical Staff Membership and/or for Clinical Privileges, and shall result in a Practitioner’s clinical privileges being automatically suspended. The intent of this section is to give the Practitioner and the MEC time to determine how to proceed appropriately when an unusual number of Code of Conduct reports is received within a short time, and not to impose corrective action or a precautionary suspension.

If the Chief of Staff, CEO or Chief of the applicable Service (the “Chief”) receives three substantiated reports of a Practitioner violating the Code of Conduct in any twelve (12) month period, the Practitioner’s clinical privileges shall be automatically and immediately suspended. If a Practitioner is subject to more than one (1) such suspension in twenty-four (24) consecutive months, all such reports in that period shall immediately be considered requests for corrective action investigation by the CEO and/or Chief of Staff, and immediately forwarded to the MEC, which shall initiate an investigation as described in Section VII.B.

VII.D.5 MEDICAL RECORDS

Members are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee and defined in these Bylaws and/or rules and regulations of the Medical Staff. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, may be imposed by the Chief of Staff, or his or her designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section VII.D.4., "related privileges" means scheduling surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff or his or her designee.

If a member remains suspended pursuant to this Section VII.D.4. for longer than thirty (30) days, the Chief of Staff may notify the member in writing that his or her membership and clinical privileges will terminate unless he or she completes all outstanding medical records within fifteen (15) days following receipt of that notice. If the member fails to complete all outstanding medical records within fifteen (15) days following receipt of this notice, the member shall be deemed to have relinquished his or her membership and clinical privileges voluntarily. Members whose clinical privileges are automatically suspended and/or who have resigned their membership pursuant to a failure to complete medical records shall not be entitled to the procedural rights set forth in Article...

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VIII unless the suspension is reportable to the National Practitioner Data Bank pursuant to 42 U.S.C. § 11101 et seq. and 45 C.F.R. § 60 et seq., or their successors.

VII.D.6 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

Failure of a member without good cause to appear and satisfy a special appearance requirement shall be a basis for corrective action.

VII.D.7 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance in amounts determined by the Medical Executive Committee and Board of Trustees shall be grounds for automatic suspension of a member's clinical privileges, and if within thirty (30) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, his or her membership shall be automatically terminated. A failure to provide such evidence within six (6) months after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of membership and clinical privileges. Members whose clinical privileges are automatically suspended and/or who have resigned their membership pursuant to the provisions of this Section VII.D.6 (failure to maintain professional liability insurance) shall not be entitled to the procedural rights set forth in Article VIII.

VII.D.8 FAILURE TO PAY DUES

Failure to pay dues, after written warning of delinquency, will result in membership and clinical privileges being automatically suspended and shall remain so suspended until the member pays the delinquent dues. A failure to pay such dues within six (6) months after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of membership and clinical privileges. Members whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provisions of this Section VII.D.7 (failure to pay dues) shall not be entitled to the procedural rights set forth in Article VIII.

VII.D.9 NOTICE OF AUTOMATIC SUSPENSION; TRANSFER OF PATIENTS

Whenever a member's privileges are automatically suspended in whole or in part, notice of such suspension shall be given to the member, the Medical Executive Committee, the Chief Executive Officer, and the Board of Trustees. Giving of such notice shall not, however, be required in order for the automatic suspension to become effective. In the event of any such suspension, the patients whose treatment are affected by the automatic suspension shall be assigned to another physician, dentist, podiatrist, chiropractor, or psychologist by the Chief of Staff. The wishes of the patient and the physician, dentist, podiatrist, chiropractor, or psychologist shall be considered, where feasible, in choosing a substitute practitioner.

VII.D.10 TERMINATION OF EXCLUSIVE CONTRACT

A member who has entered into a contract to provide services to the Hospital on an exclusive basis either as an individual or through a group practice shall be automatically terminated from the Medical Staff upon termination of an individual or group contract or upon leaving a group that has
an exclusive contract with the Hospital. Notwithstanding the foregoing, the Board of Trustees may permit individuals whose exclusive group or individual contract has terminated or who have left a group that has an exclusive contract to remain on the Staff upon such occurrence if the individual agrees not to have privileges in the specialty subject to the exclusive arrangement in the specialty subject to the exclusion. Notwithstanding the foregoing, an individual (1) who provides services to the Hospital through an exclusive group or individual contract immediately following a terminated exclusive contract shall not be automatically terminated from the Medical Staff, or (2) who has privileges to provide services which are not the subject of the exclusive contract shall not be automatically terminated as long as s/he forfeits his/her privileges which are the subject of the exclusive contract.

VII.D.11 FAILURE TO PARTICIPATE IN PEER REVIEW

Failure to participate in peer review will result in membership and clinical privileges being automatically suspended except in specific clinical cases and shall remain so suspended until the member resumes his/her participation in peer review at the discretion of the Medical Executive Committee. A failure to resume participation in peer review within six (6) months after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of membership and clinical privileges. Members whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provisions of this Section (failure to participate in peer review) shall not be entitled to the procedural rights set forth in Article VIII.

VII.E. FAILURE TO ABIDE BY CORRECTIVE ACTIONS THAT DO NOT AFFECT CLINICAL PRIVILEGES

If corrective action is taken against a member that does not restrict, affect, or terminate clinical privileges and the member fails to comply with the corrective action, the member shall be subject to precautionary suspension under Section VII.C.

VII.F. BOARD OF TRUSTEES ACTION

The procedures specified herein shall not preclude the Board of Trustees from taking any direct action or utilizing other methods for dealing with disruptive or other physician conduct relating to his/her duties and responsibilities as a member of the Medical Staff.

VIII. HEARINGS AND APPELLATE REVIEWS

VIII.A. GENERAL PROVISIONS

VIII.A.1. POLICY

No applicant entitled to a hearing may be denied membership or clinical privileges, nor may any member have his or her rights or attendant responsibilities terminated or reduced, or his or her privileges reduced, suspended, revoked, or refused for renewal, or additional privileges denied without being provided the following due process:

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a. a contemporaneous written explanation containing the explicit reasons for taking the action;

b. reasonable advance notice of the right to request a fair hearing which would afford the applicant or member an opportunity to adequately prepare a rebuttal to the stated reasons for the action;

c. a fair hearing including the right to present evidence and call witnesses on his or her behalf;

d. a written decision containing explicit reasons for taking the action substantially based on the evidence produced at the hearing; and

e. access to a complete record documenting all preliminary and final decision and proceedings related to the decisions.

VIII.A.2. EXHAUSTION OF REMEDIES

If adverse action described in Section VIII.B. is taken or recommended, the applicant or member agrees to follow and complete the procedures set forth in these Bylaws, including appellate procedures, before attempting to obtain judicial relief related to any issue or decision which may be subject to a hearing or appeal under this Article VIII. Recommended adverse actions described in Section VIII.B. shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived.

VIII.A.3. INDIVIDUAL EVALUATIONS VS. REQUESTS TO REVIEW RULES AND REQUIREMENTS

The sole purpose of the hearings and appeals provided in this Article VIII is to evaluate individual practitioners on the basis of Bylaws, rules and regulations, policies and standards of the Medical Staff and Hospital. The judicial review committees provided for in this Article VIII have no authority to modify, limit or overrule any established Bylaw, rule, regulation, policy or requirement (collectively, "rules or requirements"), and shall not entertain challenges to such rules and requirements. Any practitioner who wishes to challenge an established rule or requirement must notify the Medical Executive Committee and the Board of Trustees of the rule or requirement s/he wishes to challenge and of the basis for the challenge. The Board of Trustees shall then consult with the Medical Executive Committee regarding the request.

VIII.A.4. DEFINITIONS

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article VIII:

a. "Body whose decision prompted the hearing" refers to the Medical Executive Committee in all cases where the Medical Executive Committee or authorized designee(s) made the recommendation which resulted in a hearing being requested. It refers to the Board of Trustees in all cases where the Board of Trustees or authorized designee(s) or committee(s)
of the Board of Trustees took the action or rendered the decision which resulted in a hearing being requested.

b. "Practitioner" refers to the physician who has requested a hearing pursuant to Section VIII.C. of this Article VIII.

c. "Date of receipt" of any notice or other communication shall be deemed to be the date it was delivered personally to the addressee or, if delivered by regular or certified mail, five (5) working days after it was postmarked, postage prepaid, in the United States mail.

VIII.A.5. SUBSTANTIAL COMPLIANCE

Technical non-prejudicial or insubstantial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

VIII.A.6. WRITTEN NOTICES

All notifications and responses between the Chief of the Medical Staff and the practitioner relative to adverse or restrictive actions and hearings shall be in writing by personal delivery or by Certified Mail, Return Receipt Requested.

VIII.B. GROUNDS FOR HEARING

VIII.B.1. CORRECTIVE ACTIONS GIVING RISE TO A HEARING

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse actions and constitute grounds for a hearing, only if the action or recommendation is reportable to the National Practitioner Data Bank, pursuant to 42 U.S.C. § 11101 et seq. and 45 C.F.R. § 60 et seq., or their successors:

a. denial of a completed application for reappointment to the Medical Staff for any reason, except where (i) the application does not meet the minimum objective requirements set forth in the Bylaws or appointment procedure; or (ii) the applicant is requesting clinical privileges in a subspecialty or service in which the number of Medical Staff appointees has been limited in accordance with the Bylaws;

b. denial of requested advancement or requested change in Medical Staff category, except for any denial resulting from failure to meet the minimum objective criteria for the requested category;

c. involuntary demotion to lower Medical Staff category or membership status;

d. imposition of or restrictions on Medical Staff privileges or membership for a cumulative total of more than thirty (30) days in any twelve (12) month period;
e. revocation of Medical Staff membership except where continued appointment to the Medical Staff was contingent upon the continuance of a contractual relationship with the Hospital;

f. reduction in or failure to renew clinical privileges, other than (i) a temporary restriction in accordance with the Bylaws; or (ii) where the Medical Staff member no longer meets the minimum objective criteria for such privileges;

g. revocation or suspension of clinical privileges, other than a temporary suspension (less than 29 days) as provided by the Bylaws;

h. denial of a completed application for initial appointment or reappointment to the Medical Staff;

i. imposition of restrictions on Medical Staff privileges or membership for a cumulative total of more than thirty (30) days in any twelve (12) month period;

j. revocation of Medical Staff membership;

k. reduction in or involuntary failure to renew clinical privileges;

l. revocation or suspension of clinical privileges, for more than thirty (30) days (except probationary suspension)

m. any other action or recommendation “adversely affecting” (as such term is defined in Section 431(1) of the Act) any applicant or Medical Staff appointee.

VIII.B.2. ACTIONS NOT GIVING RISE TO A HEARING

A professional review body shall not be deemed to have made a proposal for an adverse recommendation or action, or to have made such a recommendation or to have taken such an action, and a hearing right under this section shall not have arisen in any of the following circumstances:

a. the appointment of an ad hoc investigation committee;

b. the conduct of an investigation into any matter;

c. the restriction or suspension of a Medical Staff appointee's clinical privileges for a period of not longer than fourteen (14) days while an investigation is pending;

d. the formulation and presentation of any preliminary report of any ad hoc investigation committee to the Chief Executive Officer or to the officers of the Medical Executive Committee;

e. the making of a request or issuance of a directive to an applicant or Medical Staff appointee to appear at an interview or conference before the Credentials Committee, any ad hoc
investigation committee, the Chief Executive Officer, the Board of Trustees, or any other professional review body in connection with any investigation prior to a proposed adverse recommendation or action;

f. the denial of or refusal to accept an application for initial appointment or reappointment to the Medical Staff (i) where the application is incomplete; (ii) where the application reflects that the applicant does not meet the minimum objective requirements for appointment or reappointment; or (iii) where the applicant is requesting clinical privileges in a subspecialty or service in which the number of Medical Staff appointees has been limited in accordance with the Bylaws;

g. the denial or revocation of temporary privileges in accordance with the Bylaws;

h. the appointment of a newly-appointed Medical Staff member to the provisional staff;

i. automatic termination as provided by the Bylaws;

j. the imposition of supervision or observation on a Medical Staff member which supervision or observation does not restrict the clinical privileges of the Medical Staff appointee or the delivery of professional services to patients;

k. the issuance of a letter of warning, admonition, or reprimand;

l. requirement of corrective counseling;

m. a recommendation that the Medical Staff member be directed to obtain retraining, additional training, or continuing education;

n. the denial of a request for a waiver or reduction of the required minimum liability insurance coverage as provided in the Bylaws;

o. any change in Medical Staff category resulting from the failure of a Medical Staff member to meet the minimum objective criteria for a specific category; or

p. any recommendation or action not “adversely affecting” (as such term is defined in Section 431(1) of the Act) any applicant or Medical Staff appointee, or which is not based upon a subjective determination of the professional competency or conduct of the applicant or Medical Staff appointee.

VIII.C. REQUESTS FOR HEARING

VIII.C.1. NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section VIII.B., said person(s) or body shall give the practitioner prompt written notice of the recommendation or final proposed action, the reasons for the proposed action, notice of the right

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to request a hearing pursuant to Section VIII.C.2., notice that such hearing must be requested within thirty (30) days, and a summary of the practitioner's rights in the hearing.

VIII.C.2. REQUEST FOR HEARING

The practitioner shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Chief of Staff with a copy to the Chief Executive Officer. In the event the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

VIII.C.3. TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within thirty (30) days, give notice to the practitioner of the time, place and date of the hearing. Unless extended by the judicial review committee (per Section VIII.C.5.), the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than ninety (90) days from the date of receipt of the request for a hearing; provided, however, that when the request is received from a practitioner who is under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made consistent with the goal of completing any corrective action proceedings and also holding a single hearing.

VIII.C.4. NOTICE OF CHARGES

No less than fifteen (15) days prior to the hearing, the Chief of Staff, on behalf of the body whose decision prompted the hearing, shall state clearly and concisely in writing the reasons for the adverse final proposed action taken or recommended, including the acts or omissions with which the practitioner is charged, a list of the charts in question, where applicable; and a list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose decision prompted the hearing. Such a notice may be amended at any time prior to fifteen (15) days before the scheduled date of the hearing. Notice of Charges may, however, be amended less than fifteen (15) days prior to the scheduled date of hearing, but the affected practitioner may obtain a continuance of the hearing of no less than fifteen (15) days from the date s/he receives the amended Notice of Charges.

VIII.C.5. JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the Chief of Staff shall appoint a judicial review committee consisting of at least three (3) Medical Staff members, and alternates as appropriate, who shall be unbiased, shall not have actively participated in the formal consideration of the matter at any previous level (i.e., they shall not have acted as an accuser, investigator, fact finder or initial decision-maker in the same matter), and shall stand to gain no direct financial benefit from the outcome. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the judicial review committee. In the event that it is not feasible to appoint a judicial review committee from the active Staff, the Chief of Staff may appoint members from other Staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the chief. Membership on a judicial review committee shall include, where

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feasible, an individual practicing the same specialty as the practitioner. Either party shall have the opportunity to veto one member of the proposed judicial review committee one time.

VIII.C.6. FAILURE TO APPEAR OR PROCEED

Failure without good cause of the practitioner to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

VIII.C.7. POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the judicial review committee, or its chief acting upon its behalf, within the discretion of the committee or its chief, on a showing of good cause.

VIII.D. HEARING PROCEDURE

VIII.D.1. PROCEDURE PRIOR TO HEARING

a. Each party, at least ten (10) days prior to the hearing, shall furnish to the other a written list of the names and addresses of the individuals, so far as is then actually anticipated, who will give testimony or evidence in support of that party at the hearing. The witness list shall be amended when additional witnesses are identified. A failure to comply with this requirement is good cause to postpone the hearing.

b. Not less than ten (10) days prior to the hearing, each party shall provide the other with copies of all documents relevant to the charges and any document the party intends to introduce into evidence at the hearing.

c. The body whose decision prompted the hearing may object to the introduction of the evidence that was not provided by the practitioner during an appointment, reappointment or privilege application review or during corrective action, despite the requests of the peer review body for such information. The information will be barred from the hearing by the hearing officer (per Section VIII.D.3.) unless the practitioner can prove s/he previously acted diligently and could not have submitted the information.

d. The practitioner shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer. Challenges to the impartiality of any judicial review committee member or the hearing officer shall be ruled on by the hearing officer.

e. It shall be the duty of the practitioner and the body whose decision prompted the hearing to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
VIII.D.2. REPRESENTATION

The practitioner and the body whose decision prompted the hearing shall be entitled to be accompanied by and represented at the hearing by legal counsel.

VIII.D.3. THE HEARING OFFICER

The Chief of Staff shall appoint a hearing officer to preside at the hearing. The hearing officer may but need not be an attorney at law qualified to preside over a quasi-judicial hearing, and preferably have experience in Medical Staff matters. The hearing officer shall not be an attorney regularly utilized by the Hospital for Medical Staff matters. The hearing officer shall gain no direct financial benefit from the outcome and shall not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and arguments during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. The hearing officer shall have the authority and discretion to grant continuances, to decide when evidence may not be introduced, to rule on challenges to judicial review committee members, and to rule on challenges to himself or herself serving as hearing officer. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

VIII.D.4. RECORD OF THE HEARING

A shorthand reporter shall be present to make a record of the hearing, proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The hearing officer may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

VIII.D.5. RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant evidence, exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination.
VIII.D.6. MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article VIII. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The judicial review committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. Both sides may file a written statement at the close of the hearing.

VIII.D.7. BURDENS OF PRESENTING EVIDENCE AND PROOF

Whenever a hearing relates solely to a proposed denial of (i) appointment to the Medical Staff, (ii) requested clinical privileges, or (iii) requested advancement in Medical Staff category, the applicant or Medical Staff appointee who requested the hearing shall have the burden of proving, by clear and convincing evidence, (i) that s/he meets the standards for appointment or reappointment to the Medical Staff or for the granting of the clinical privileges or Medical Staff category requested, and (ii) that the denial of appointment or reappointment, requested clinical privileges, or requested advancement in Medical Staff category would be arbitrary and capricious. In all other cases, the professional review body that proposed the adverse recommendation or action shall present supporting evidence, but the Medical Staff appointee shall have the burden of proving, by a preponderance of the evidence, that the proposed adverse recommendation or action should be rejected and/or modified, in whole or in part.

VIII.D.8. ADJOURNMENT AND CONCLUSION

The hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed. The judicial review committee shall thereupon, outside of the presence of the parties, conduct its deliberations and render a decision and accompanying written report. Final adjournment shall not occur until the judicial review committee has completed its deliberations.

VIII.D.9. BASIS FOR DECISION

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

VIII.D.10. DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within forty-five (45) days after final adjournment of the hearing (or within thirty (30) days if the practitioner is currently under suspension), the judicial review committee shall render a decision which shall be accompanied by a report in writing. The judicial review committee may lessen the punishment imposed, but if the imposed punishment is reportable to the National Practitioner Data Bank, in no event may such reduced punishment be less than that which is reportable to the National Practitioner Data Bank. A copy of said decision shall be forwarded to the Medical Staff.

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Executive Committee, the Chief Executive Officer, the Board of Trustees, and to the practitioner. The report shall contain a concise statement of the reasons in support of the decision, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the practitioner and the body whose decision prompted the hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the judicial review committee shall be subject to such rights of appeal or review as described in these Bylaws.

VIII.E. APPEAL

VIII.E.1. TIME FOR APPEAL

Within thirty (30) days after receipt of the decision of the judicial review committee, either the practitioner or the body whose decision prompted the hearing may request an appellate review. A written request for such review shall be delivered to the Chief of Staff and the other party in the hearing. If a request for appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Board of Trustees within ninety (90) days. The recommendation shall be considered, but shall not be binding on the Board of Trustees.

VIII.E.2. GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal.

VIII.E.3. APPEAL PROCEDURE

An appeals proceeding shall be governed by the following procedural rules and any applicable law governing hospital districts:

a. An appeal to the Board of Trustees shall be held on the record of the judicial review committee hearing.

b. Each party may submit a written statement to the Board of Trustees on appeal.

c. There is no right to oral argument on appeal.

VIII.E.4. DECISION

a. Within thirty (30) days after conclusion of the appellate proceedings, the Board of Trustees shall render a final decision. The Board of Trustees shall give great weight to the recommendation of the judicial review committee and shall not act arbitrarily or capriciously. The Board of Trustees is allowed, however, to exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, and whether the judicial review committee's decision is reasonable and warranted.
b. Following conclusion of the proceeding as outlined in Section VIII.E.3., the Board of Trustees shall send notice of its final decision to the Medical Executive Committee, and, through the Chief Executive Officer, to the affected practitioner. The decision shall be immediately effective and final, and shall not be subject to further hearing.

c. The decision shall be in writing, shall specify the subject of the hearing, the reasons for the action taken, and shall be forwarded to the Chief of Staff, the Medical Executive Committee, and the Chief Executive Officer.

VIII.E.5. RIGHT TO ONE HEARING

No practitioner shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any matter which shall have been the subject of adverse action or recommendation.

VIII.F. EXCEPTIONS TO HEARING RIGHTS

VIII.F.1. TERMINATION OF TEMPORARY PRIVILEGES

No practitioner is entitled to the hearing or appeal rights provided in this Article VIII by virtue of the expiration, non-renewal or termination of temporary clinical privileges.

VIII.F.2. AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

Practitioners whose clinical privileges are automatically suspended and/or limited for any of the reasons specified in Section VII.D. of these Bylaws are not entitled to any hearing rights except to determine whether the grounds for automatic suspension have occurred and only if the practitioner is entitled to a hearing.

VIII.F.3. ALLIED HEALTH PROFESSIONALS

Allied Health Professionals are not entitled to the fair hearing rights set forth in this Article VIII of these Bylaws.

VIII.F.4. DENIAL OF APPLICATIONS FOR FAILURE TO MEET THE MINIMUM QUALIFICATIONS

Applicants shall not be entitled to any hearing or appellate review rights if their membership, privileges, applications, or requests are denied because of their failure to meet any of the minimum standards specified in Section II.B.1., III.B.1., III.C.1., III.D.1., III.E.1., and III.F.1. of these Bylaws or because of their failure to file a complete application.
IX. OFFICERS

IX.A. OFFICERS OF THE MEDICAL STAFF

IX.A.1. IDENTIFICATION

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

IX.A.2. QUALIFICATIONS

Officers must be members of the active Medical Staff at the time of their nominations and election, and must remain in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

IX.A.3. ELECTIONS

a. ELECTION OF REPRESENTATIVES TO THE MEDICAL EXECUTIVE COMMITTEE

(1) Except for the Chief Executive Officer of the Hospital, representatives to the Medical Executive Committee must be active Medical Staff members and shall be elected by members of their respective specialty groups who are active Medical Staff members at the time of the election. The election shall occur at a special, formal meeting of the specialty group scheduled no later than one month prior to the December, annual meeting of the Medical Staff. A written ballot shall be accepted (no later than the day of the special meeting) from active Medical Staff members who are unable to attend the specialty group meetings. If there is a tie between two or more nominees, the voting physicians within the specialty group shall reach agreement on one representative, using whatever tie-breaking methodology is agreed upon by the voting physicians within the specialty group. If the group cannot agree on a methodology for breaking a tie, the entire Medical Staff shall vote for that group’s representative. Results of these elections shall be posted no later than three (3) weeks prior to the annual meeting of the Medical Staff.

(2) Should a specialty group representative to the Medical Executive Committee resign, the members of the specialty group will expeditiously elect another representative in a special, formal meeting of the specialty group, with the same provision for written ballots from specialty group members who are unable to attend the specialty group meeting.

b. ELECTION OF OFFICERS

(1) The officers of the Medical Staff shall be elected at the annual meeting of the Medical Staff. The Chief of Staff will be elected from the entire active Medical Staff. Nominees for the Chief of Staff can be any active Medical Staff member regardless of whether or not they are a representative. The nominees for Vice-Chief of Staff and Secretary/Treasurer will be from the group of representatives (or remaining
representatives) who are elected at the special meetings of their respective specialty groups. Voting shall occur at the annual meeting of the Medical Staff and shall be by secret written ballot of active Medical Staff members. Absentee voting is permitted in the election of Medical Staff officers, provided the absentee ballots are received by the Medical Affairs office prior to the annual meeting of the Medical Staff. The order of election will be Chief of Staff, Vice-Chief of Staff, and Secretary/Treasurer. A nominee shall be elected upon receiving a majority of all valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, a majority vote of the current Medical Executive Committee shall decide the election by secret written ballot performed at the annual meeting.

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

(3) The Chief of Staff may or may not also be a representative of a specialty group.

(4) The chiefs of the medical and surgical services must be active Medical Staff members and will be selected from the group of representatives by the active Medical Staff members of each service, following the general election.

IX.A.4. TERM OF ELECTED OFFICE

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

IX.A.5. RECALL OF OFFICERS

Except as otherwise provided, recall of a Medical Staff officer may be initiated by the Medical Executive Committee or may be initiated by a petition signed by at least one-third (1/3) of the members of the active Medical Staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds (2/3) vote of the active Medical Staff members eligible to vote who actually cast votes at the special meeting in person or by mail ballot.

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

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

b. Failure to properly represent the Medical Staff; or

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

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IX.A.6. 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 in the active Medical Staff. Vacancies, other than that of the Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular Medical Staff meeting. In the event of a vacancy in the Office of Chief of Staff, a special election to fill the position shall occur at the next regular Medical Staff meeting.

IX.B. DUTIES OF OFFICERS

IX.B.1. CHIEF OF STAFF

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

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

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

c. calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

d. serving as Chief of the Medical Executive Committee;

e. serving as an ex officio member of all other Staff committees without vote, unless his or her membership in a particular committee is required by these Bylaws;

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

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

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

i. attendance at all regularly scheduled meetings of the Board of Trustees;

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

k. being responsible for the educational activities of the Medical Staff;
l. being a spokesperson for the Medical Staff in professional and public relations;

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

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

o. being responsible for the publication and maintenance of a roster of physicians available for emergency service at the hospital, and on call for same. It shall be the obligation of all members of the medical staff to comply with the assignments of the Chief of Staff for that purpose.

IX.B.2. VICE-CHIEF OF STAFF

The Vice-Chief of Staff shall:

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

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

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

IX.B.3. SECRETARY-TREASURER

The Secretary-Treasurer shall:

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

b. be responsible for the accurate and complete minutes of all Medical Staff meetings;

c. call Medical Staff meetings, on the order of the Chief of Staff;

d. attend to all correspondence and perform such other duties as ordinarily pertain to his or her office; and

e. assume all duties and authority of the Chief of Staff and Vice Chief of Staff in their absence.

IX.C. CHAIN OF COMMAND FOR OFFICERS

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

1. Chief of Staff;

2. Vice-Chief of Staff; and
3. Secretary-Treasurer.

X. SERVICES

X.A. ORGANIZATION OF SERVICES

The Medical Staff of the Hospital will be divided into two major services: Medicine and Surgery. A physician specializing in the area of Pathology, Radiology, Emergency Medicine or Family Practice shall be given the option to choose to be in whichever service he/she desires. This selection may be made only at the time of application or reapplication.

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

1. Each service chief shall be board certified by an appropriate medical specialty or subspecialty board or shall establish comparable competence through the credentialing process.

2. Each service chief shall be elected by the members of his or her service for a one (1) year term, as specified in Article IX.

3. Removal of the service chief during his or her term of office may be initiated by a two thirds (2/3) majority of all active Medical Staff members of the service, but no such removal shall be effective unless, and until, it has been ratified by the Medical Executive Committee.

X.C. FUNCTIONS OF SERVICE CHIEFS

Each chief of service shall, in conjunction with the appropriate committees of the Medical Staff:

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

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

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

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

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

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

7. Integrate the service into the primary functions of the Hospital;
8. Make recommendations for space and other resources needed by the service;

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

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

11. Be responsible for teaching, education, and research programs in his or her service;

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

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

X.D. FUNCTIONS OF THE SERVICE

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

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

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

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

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

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

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

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

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

X.E. ASSIGNMENT TO SERVICES

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

XI. COMMITTEES

XI.A. GENERAL PROVISIONS

XI.A.1. TERMS OF COMMITTEE MEMBERS

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

XI.A.2. QUORUM

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

XI.A.3. REMOVAL

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

XI.A.4. VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

XI.A.5. HOSPITAL REPRESENTATION

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.
XI.A.6. VOTING ON COMMITTEES

Each physician member on a Medical Staff committee will have one vote in deciding matters before the committee. The physician members of a committee may vote at the beginning of each year or during each year to allow courtesy staff, consulting staff, non-physician professional staff and/or allied health professionals to vote on matters before the committee.

XI.A.7. CONFLICT OF INTEREST

Should a committee member raise an objection to another committee member voting on a matter under consideration by the committee, and should the committee member in question disagree that a conflict of interest exists, the vote shall be deferred until the entire committee decides if a conflict of interest exists. If so, the committee member in question may be required to refrain from voting upon the matter.

XI.A.8. COMMITTEE CHAIR

The committee chair will be elected by the committee during the first meeting of the calendar year, except that the Chief of Medicine shall chair the Medical Service Committee; the Chief of Surgery shall chair the Surgical Service Committee; the perinatal service representative to the Medical Executive Committee shall chair the Perinatal Committee. Except as otherwise specified, the chair of a committee described in these Bylaws shall be a physician. At its discretion, each committee may vote to elect a committee co-chair.

XI.A.9. GUESTS

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

XI.A.10. EXECUTIVE SESSION

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

XI.B. MEDICAL EXECUTIVE COMMITTEE

XI.B.1. COMPOSITION

The Medical Executive Committee shall be a standing committee empowered to act on behalf of the Medical Staff and shall consist of seven (7) or eight (8) members of the Medical Staff, (seven members if the Chief of Staff is also a specialty group representative, and eight members if the Chief of Staff is not a representative of a specialty group), including the Chief Executive Officer or his/her designee as an ex-officio member and those listed below. The committee will be chaired by the Chief of the Medical Staff.

a. Chief of the Medical Staff

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b. Vice-Chief of Staff;

c. Secretary-Treasurer;

d. The Chief of Surgery and the Chief of Medicine, both of whom were elected by their respective services out of the group of representatives, as outlined below.

e. The representatives of the Medical Staff to the Medical Executive Committee shall be from the specialty groups listed below, plus two MEC representatives at large.

(1) Internal Medicine, Family Practice, General Practice and Psychiatry;

(2) Pediatrics and Obstetrics/Gynecology;

(3) General Surgery, Orthopaedic Surgery, and non-Orthopaedic surgical subspecialists (Two [2] members);

(4) Hospital-based specialties of Anesthesia, Emergency Medicine, Pathology, and Radiology.

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

The composition of the Medical Executive Committee should reflect the composition of the active Medical Staff. If the Medical Staff composition changes such that the representation no longer approximates the relative distribution of medical specialties, revision of the structure of representation will be performed to reflect the changes in Medical Staff composition. This review will be performed on an annual basis by the Medical Executive Committee and any changes presented to the entire Medical Staff at a mid-year meeting.

XI.B.3. DUTIES

The duties of the Medical Executive Committee shall be to:

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

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

c. receive and act upon committee reports;

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

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

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

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

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

i. make recommendations on Hospital management matters to the Board of Trustees through the Chief Executive Officer and the Joint Conference Committee;

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

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

l. provide for the preparation of all meeting programs, either directly or through delegation to a program committee, or other suitable agent;

m. to make recommendations to the Board of Trustees on the appointment or reappointment of individuals to the Medical Staff and delineation of clinical privileges;

n. to review, periodically, information available regarding the performance and clinical competence of Medical Staff members, including service recommendations and, as a result of such reviews, to make recommendations for reappointments and renewal of clinical privileges;

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

p. report at each general Medical Staff business meeting;

q. act as the Institutional Review Board (IRB) for the Hospital and Medical Staff to review clinical research proposals and monitor research projects, which do not require a formally constituted IRB (i.e., one which complies with all applicable federal IRB regulations). IRB will include at least one community member. The Board of Trustees will approve participation in clinical research projects based upon the project's compatibility with the Hospital's mission, its Staff expertise, available resources, and positive benefits;

r. in the absence of an Ethics Committee, function as the Ethics Committee for the Hospital, utilizing other individuals as consultants when necessary;
s. in the absence of a Quality Improvement Committee, function as the Quality Improvement Committee, utilizing other individuals as consultants when necessary, to review and evaluate the status and effectiveness of hospital-wide quality improvement activities. Activities reviewed may include:

(1) monitors in place;
(2) results of monitors;
(3) problems identified;
(4) actions planned;
(5) actions taken; and
(6) evidence of problem resolution.

The committee may make referrals to an individual, service or other committee in order to implement a monitor, perform further evaluation, implement corrective action, and/or provide evidence of problem-solving effectiveness, make recommendations to the Board of Trustees regarding the structure of the Medical Staff, the mechanism used to review credentials and delineate clinical privileges, the organization of the quality assessment and improvement activities, as well as the mechanism used to conduct, evaluate, and review such activities, the mechanism by which Medical Staff membership may be terminated, and the mechanism for fair hearing procedures.

XI.B.4. MEETINGS

The Medical Executive Committee shall meet at least once a month and maintain a permanent record of its proceedings and actions.

XI.B.5. VOTING

Members must be present to vote on Medical Executive Committee matters. Proxy or absentee votes shall not be permitted.

XI.B.6. REPRESENTATION

A Medical Executive Committee member who anticipates being absent from a Medical Executive Committee meeting may arrange to send a representative of the same specialty in his/her place to the Medical Executive Committee meeting at the discretion of the Chief of Staff or the Chief of Staff’s designee. Such representative shall be permitted to participate in discussion, but shall not be permitted to vote on committee matters.
XI.B.7. CONFLICT OF INTEREST

Should a Medical Executive Committee member raise an objection to another Medical Executive Committee member voting on a matter under consideration by the Medical Executive Committee, and should the Medical Executive Committee member in question disagree that a conflict of interest exists, the vote shall be deferred until the entire Medical Executive Committee decides if a conflict of interest exists. If so, the Medical Executive Committee member in question may be required to refrain from voting upon the matter.

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

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

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

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

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

E. Recall of an MEC member-at-large shall require a majority vote of the active Medical Staff members eligible to vote who actually cast votes at the special meeting in person or by written ballot submitted prior to the special meeting.

F. Permissible bases for recall of an MEC representative include, without limitation:

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

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

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

XI.B.9 MEDICAL EXECUTIVE COMMITTEE VACANCIES

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

XI.C. CREDENTIALS COMMITTEE

XI.C.1. COMPOSITION

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

XI.C.2. FUNCTIONS

The duties of the Credentials Committee shall be to:

a. review credentials files, including new physicians, non-physician professional staff and allied health professional staff applications, reappointment applications, requests for change in privileges or Staff status;

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

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

XI.C.3. MEETINGS

The Credentials Committee shall meet at least once a month and maintain a permanent record of its proceedings and actions.

XI.D. THE PROFESSIONAL ACTIVITIES COMMITTEES

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

XI.D.1. PHARMACY AND THERAPEUTICS/NUTRITIONAL SUPPORT COMMITTEE

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

b. Meetings. The Pharmacy and Therapeutic/Nutritional Support Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings, and actions, and shall make a regular report to the Medical Executive Committee.

c. Functions. The Pharmacy and Therapeutics/Nutritional Support Committee shall have the following functions:
(1) serve as an advisory group to the Medical Staff, and to the Hospital pharmacist on matters pertaining to the choice of available drugs;

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

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

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

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

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

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

(8) coordinate action on findings from the committee and the Medical Staff;

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

(10) report Drug Usage Evaluation on a quarterly basis;

(11) provide a standard of care for nutritional support as a service of the Hospital;

(12) monitor patients receiving supplemental nutrition;

(13) provide information and assistance to Hospital staff through inservice and resource material; and

(14) monitor admissions and screen cases for potential nutritional risk.

XI.D.2. EMERGENCY SERVICES COMMITTEE

a. Composition.

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

b. Meetings.
The Emergency Department Committee shall meet at least bi-monthly, maintain a permanent record of its findings, proceedings and actions, and shall report regularly to the Medical Executive Committee.

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

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

(2) develop, and keep current by an annual review, a procedure manual relating to emergency and ambulatory services;

(3) develop appropriate medical record forms (following the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) guidelines), for use in the emergency/outpatient areas;

(4) coordinate with the Teton County Emergency Medical Services Council, whose EMT members operate the ambulance service in the county, to promote efficient and effective pre-hospital care for ill and injured patients;

(5) review the emergency/outpatient records monthly to evaluate the appropriateness and quality of care;

(6) develop and implement a plan for the care of mass casualties (according to JCAHO guidelines), at the time of a major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. When approved by the Medical Staff and the Board of Trustees, the plan will be available in the emergency department;

(7) see that this disaster plan is rehearsed at least twice a year, preferably as part of a coordinated drill in which other community service agencies also participate. A written report and evaluation of all drills, and actual disasters, shall be made; and

(8) perform quality assurance/quality improvement peer review activities.

XI.D.3. MEDICAL EDUCATION COMMITTEE

a. Composition. This Medical Education Committee shall be composed of at least three (3) physicians, the Hospital's inservice director, Medical Staff Coordinator and other interested practitioners.

b. Function. The Medical Education Committee shall be responsible for:
(1) analyzing the changing needs of the Hospital's library service. These activities shall include the deletion of outmoded material, as well as the recommendation for the acquisition of new materials; and

(2) providing continuing medical education programs for the Medical Staff which relate to the type and nature of care offered by the Hospital and relate to the findings of performance improvement activities.

(3) overseeing the preceptee program, including the following:
   - soliciting input from preceptees and the practitioners supervising preceptees regarding the safety and quality of patient care, treatment and services provided by, and the related educational and supervisory needs of, the preceptees; and
   - receiving input from Medical Staff Coordinator about the quality of care, treatment and services and educational needs of the preceptees; and
   - reviewing preceptees’ evaluations of their clinical rotations at the Hospital and reviewing supervising practitioners’ evaluations of the preceptees to identify problem trends; and
   - recommending and when appropriate implementing improvements to the program based upon the above input; and
   - communicating with the Medical Staff and Board of Trustees regarding the safety and quality of patient care, treatment and services provided by, and the related educational and supervisory needs of, the preceptees

XI.D.4. MEDICAL STAFF BYLAWS COMMITTEE

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

b. Function. The Medical Staff Bylaws Committee shall:

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

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

XI.D.5. INTENSIVE CARE UNIT (ICU) COMMITTEE

a. Composition. Members will include one member appointed by the chief of medicine, one member appointed by the chief of surgery, one member appointed by the chief of anesthesiology, one Emergency Department physician, a representative from respiratory therapy, the ICU
coordinator, and any additional members appointed by the Chief of Staff. An EMT representative may be an ex-officio member.

b. Meetings.
The Intensive Care Unit Committee will meet at least bi-monthly separately or as part of the Medical Service Committee meeting.

c. Functions.
The functions of the Intensive Care Unit Committee will be to:

(1) upgrade ICU policies;

(2) approve and review new ICU policies;

(3) discuss any Hospital procedures that would affect the ICU;

(4) organize and implement appropriate continuing education for those involved in ICU patient care;

(5) coordinate Basic and Advanced Cardiac Life Support classes and practice drills;

(6) arrange for continuation of CPR certification classes for Staff members, Hospital Staff, and other interested individuals, via the inservice coordinator;

(7) maintain, and periodically revise, the "CODE BLUE" policy, and conduct mock "CODE BLUE" drills for Staff practice;

(8) supervise and arrange for the organization of crash carts for appropriate areas of the Hospital;

(9) report to the appropriate Medical Staff and Hospital committees, and to Hospital Administration; and

(10) perform quality assurance/quality improvement peer review activities.

XI.D.6. PERINATAL COMMITTEE

a. Composition.
The Perinatal Committee shall be composed of those practitioners involved in practicing obstetrics and newborn pediatrics, as well as appropriate representatives from anesthesia service and the nursing staff, including the charge nurse of the OB/Nursery section. The committee will be chaired by the Perinatal representative to the Medical Executive Committee.

b. Meetings.
The Perinatal Committee will meet at least bi-monthly, and shall present reports of its meetings to the Medical Executive Committee.
c. Function. The functions of the Perinatal Committee will be to:

(1) review policies and procedures regarding maternal and newborn perinatal care;

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

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

(4) perform perinatal quality assurance/quality improvement peer review activities

XI.D.7. MEDICAL SERVICE COMMITTEE

a. Composition.  
The Medical Service Committee will be composed of all physicians assigned to the medical service, appropriate AHPs, representatives of the nursing staff, ancillary services representative, CEO and risk manager. The committee will be chaired by the Chief of Medicine.

b. Meetings.  
The Medical Service Committee will meet at least bi-monthly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report regularly to the Medical Executive Committee.

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

(1) Review policies and procedures regarding non-surgical care;

(2) provide appropriate continuing education for nurses and other individuals involved in the care of non-surgical patients;

(3) be particularly attentive to mortality, morbidity, infection control; and

(4) perform quality assurance/quality improvement peer review activities within the non-surgical area.

XI.D.8. SURGICAL SERVICE COMMITTEE

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

b. Meetings.
The Surgical Service Committee will meet at least bi-monthly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report regularly to the Medical Executive Committee.

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

(1) review policies and procedures regarding surgical care;

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

(3) be particularly attentive to mortality, morbidity, and infection control; and

(4) perform quality assurance/quality improvement peer review activities within the surgical area.

XI.D.9 AD HOC COMMITTEES

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

XI.E. MEDICAL STAFF—HOSPITAL JOINT COMMITTEES

XI.E.1. INFECTION CONTROL COMMITTEE

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

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

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

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

(2) sterilization procedures by heat, chemicals or otherwise;
XI.E.2. SAFETY COMMITTEE

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

b. Meetings.
The Safety Committee will meet at least monthly, shall maintain a permanent record of its proceedings, and shall report regularly to the Medical Executive Committee and Joint Conference Committee.

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

1. review safety-related items and also to review incident reports, such as employee injuries, needle injuries, etc.;

2. develop written policies and procedures designed to enhance safety within the Hospital, and on its grounds, to the maximum degree possible; and

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

XI.E.3. RADIATION SAFETY COMMITTEE

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

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

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

(1) Review the qualifications of proposed users and uses of radioactive materials;

(2) Monitor the implementation and use of the NRC ALARA program;

(3) Through the Radiation Safety Officer (RSO), the Radiation Safety Committee will perform an annual review of the Radiation Safety Program and recommend remedial action to correct any deficiencies; and

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

XI.F. JOINT CONFERENCE COMMITTEE

1. Composition. The Joint Conference Committee shall be a standing committee, composed of three (3) members of the Medical Staff and three members of the Board of Trustees. The Chief Executive Officer and Medical Director for Quality Affairs shall be ex-officio members without voting privileges. The representatives from the Medical Staff shall include the Chief of Staff and two (2) additional Medical Executive Committee members as appointed by the Chief of Staff.

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

3. Functions. The Joint Conference Committee shall conduct itself as a forum for the discussion of matters of Hospital policy and practice, especially those pertaining to efficient and effective patient care, and shall provide liaison with the Board of Trustees and the Chief Executive Officer. The leadership of the organization-wide performance improvement initiative is provided by the Joint Conference Committee. The committee determines strategic direction and vision for the organization’s performance improvement efforts. It shall have the following specific duties:

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

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

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

d. Performance/Quality Improvement. Assess organization-wide needs for performance improvement efforts through periodic review of the following:

(1) clinical and health status performance indicators (medical, surgical, community-wide);

(2) direct requests from Medical Staff, hospital staff, patients/families, community and others, either directly or via Performance Improvement Forms;

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

(4) benchmarking comparisons with other organizations; and

(5) findings of surveys and reviews by external bodies.

e. Identify the highest priority performance improvement opportunities;

f. Promote, support and empower performance improvement project teams;

g. Determine the need for and facilitate the provision of training, education and support materials in performance improvement;

h. Provide general oversight and support for departmental, organization-wide and Medical Staff performance improvement and monitoring activities;

i. Communicate/report performance improvement activities, results and requirements to Board of Trustees, Medical Staff, hospital staff and community as appropriate; and

j. Maintain strict confidentiality regarding sensitive information as provided for in hospital, Medical Staff and Board of Trustees policies, bylaws, rules and regulations.
XI.G. PSYCHOLOGY COMMITTEE

1. Composition. The Psychology Committee shall be composed of all psychologists and some or all allied mental health professionals. Psychologists shall be voting members; allied mental health professionals shall be non-voting members.

2. Meetings. The Psychology Committee shall meet at least bi-monthly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report regularly to the Behavioral Services Committee.

3. Functions. The functions of the Psychology Committee will be to:
   a. serve as an advisory committee to the Behavioral Services Committee regarding all aspects of the practice of psychology in the Hospital;
   b. review credentials of psychologists and allied mental health professional candidates for Hospital privileges (to be done by Psychology Committee chair);
   c. conduct biennial performance review of the psychologists and allied mental health professionals;
   d. develop, review, update and recommend to the Behavioral Services Committee policies, procedures and changes to the Medical Staff Bylaws and rules and regulations having to do with the practice of psychology services; and
   e. take up other relevant business as requested by the Behavioral Services Committee.

XI.I QUALITY AND PERFORMANCE MONITORING COMMITTEE

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

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

3. Functions. The Quality and Performance Monitoring Committee shall function as the primary hospital peer review committee under the direction of the Medical Executive Committee. The functions of the Quality and Performance Monitoring Committee will be to:
   a. reengineer the Medical Staff’s approach to peer review/quality monitoring and to meeting all applicable JCAHO standards;
   b. monitor overall clinical performance and individual practitioners’ performance;
c. develop, review and report type 1, 2, and 3 performance indicators; and

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

XI.J. TRAUMA PROGRAM AND TRAUMA COMMITTEE

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

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

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

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

5. Multidisciplinary Trauma Committee.

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

7. Meetings. The trauma committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report regularly to the Medical Executive Committee.

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

XII. MEDICAL STAFF MEETINGS

XII.A. REGULAR MEETINGS

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

2. Educational meetings for the Medical Staff will be presented at least quarterly, dealing with items of particular importance to patient care within the Hospital. These presentations may be made by members of the Medical Staff, or by invited speakers from outside the Medical Staff. The presentation may be supplemented by the inclusion of business matters, such as review of reports by the various services, reports of peer review activities by the medical and surgical services, reports by the nursing service, and any other items of business or interest to the Medical Staff.

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

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

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

XII.B. SPECIAL MEETINGS

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

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

Approved by General Medical Staff: December 18, 2014
Approved by Board of Trustees: January 28, 2015
3. No business shall be transacted at any special meeting of the Medical Staff, except that stated in the notice calling the meeting.

XII.C. QUORUM

The presence of two-thirds (2/3) of the total membership of the active Medical Staff with voting privileges either in person or by written ballot submitted prior to the meeting at which a vote is taken, will be required for election of officers. The presence of fifty percent (50%) of the membership of the active Medical Staff with voting privileges shall constitute a quorum for all other actions, except that a quorum for committee or service meetings may be changed, as specified in Section XIII.D. of these Bylaws.

XII.D. ATTENDANCE

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

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

3. The Medical Staff Office will submit a complete attendance record of each active and provisional Medical Staff member to the Medical Executive Committee before the annual election of MEC representatives in November. If the active Staff member has not met the 50% attendance requirement, his or her eligibility to vote (1) in the election of MEC representative(s); (2) in the election of Medical Staff officers and Chiefs of Service; (3) on Bylaws or rules and regulations changes; and (4) on any other matter that comes up before the entire Medical Staff, will be restricted for twelve (12) months, at which time his or her meeting attendance for the past twelve months will be assessed to determine his or her eligibility to vote on those items listed above. The Staff member will continue to have voting privileges at the meetings of those committees of which s/he is a member. Failure of the provisional Medical Staff member to meet the 50% attendance requirement may preclude his or her advancement to the active Medical Staff.

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

XII.E. SPECIAL ATTENDANCE REQUIREMENTS

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

2. Failure by a Staff member to attend any meeting with respect to which s/he was given notice that attendance was mandatory, unless excused by the Medical Executive Committee upon a showing of good cause, shall result in an automatic suspension of all, or of such portion of the staff member's clinical privileges as the Medical Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary. In all other cases, if the Staff member shall make a timely request for postponement, supported by an adequate showing that his or her absence will be unavoidable, such presentation may be postponed by the Chief of Staff, or by Medical Executive Committee if the Chief of Staff is the Staff member involved. Such postponement shall be for no longer than until the next regular meeting, otherwise the pertinent clinical information shall be presented and discussed as scheduled.

XII.F. CONFLICT OF INTEREST

Should a Medical Staff member raise an objection to another Medical Staff member voting on a matter under consideration by the Medical Staff, and should the Medical Staff member in question disagree that a conflict of interest exists, the vote shall be deferred until the entire Medical Staff who are present decide if a conflict of interest exists. If so, the Medical Staff member in question may be required to refrain from voting upon the matter.

XIII. COMMITTEE AND SERVICE MEETINGS

XIII.A. REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings without notice, other than such resolution.

XIII.B. SPECIAL MEETINGS

A special meeting of any committee or service may be called by, or at the request of, the chair thereof, by the Chief of the Staff, or by one-third (1/3) of the committee's current physician members, but by not less than two (2) physician members.

XIII.C. NOTICE OF MEETINGS

1. Written or oral notice, stating the place, day, and hour of any regular or special meeting, not held pursuant to resolution, shall be given to each member of the committee or service, not less than five (5) days before the time of such meeting, by the person(s) calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail, addressed to the member at his or her address as it appears on the records of the Hospital, with postage thereon prepaid.

2. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.
XIII.D. QUORUM FOR COMMITTEE MEETINGS

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

XIII.E. MANNER OF ACTION

The action of a majority of the members present at a meeting, at which a quorum is present, shall be the action of a committee. Action may be taken without a meeting by unanimous consent, in writing setting forth the action so taken, and signed by each member entitled to vote thereat.

XIII.F. RIGHTS OF EX OFFICIO MEMBERS

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum, nor shall they have the right to vote.

XIII.G. MINUTES

Minutes of each regular and special meeting of a committee shall be prepared, and shall include a record of the attendance of members and the vote taken on each matter. The Medical Affairs office shall provide a draft of the minutes to the committee chair within one week after the meeting for his or her review. The minutes shall be signed by the chairperson, and a report thereof shall be forwarded to the Medical Executive Committee. The Medical Affairs office shall maintain a permanent file of the minutes of each committee meeting.

XIV. CONFIDENTIALITY, IMMUNITY, AND RELEASES

XIV.A. GENERAL

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at the Hospital. All acts, communications, reports, recommendations or disclosures addressed in this Article XIV shall pertain to those acts, communications, reports, recommendations or disclosures performed by members of the Staff and Board of Trustees ONLY while functioning in some official capacity for the Hospital.

XIV.B. IMMUNITY FROM LIABILITY

1. Any person who, in good faith, participates in any Hospital activities related to the evaluation and improvement of the quality of care, including those activities described in Section XIV.B.3. below, shall be immune from civil liability in connection with such participation.

2. The immunity described in Section XIV.B.1. shall not apply to any grossly negligent, intentional or malicious acts or omissions which result in harm.
3. The immunity described in Section XIV.B.1. shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution’s activities related to:

a. applications for appointment, reappointment or clinical privileges;

b. periodic reappraisals for reappointment or clinical privileges;

c. corrective action, including summary suspension;

d. hearings and appellate reviews;

e. quality of care evaluations;

f. utilization reviews; and

g. other Hospital service committee activities related to quality of patient care and interprofessional conduct.

4. The acts, communications, reports, recommendations and disclosures referred to in this Article XIV may relate to a staff member’s professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or other matter that might directly or indirectly have an effect on patient care.

5. The consents, authorizations, releases, rights, privileges, and immunities provided by Section V.E.2. of these Bylaws, for the protection of this Hospital’s Medical Staff, other appropriate Hospital officials and personnel and third parties in connection with applications for initial appointment shall also be fully applicable to the activities and procedures covered by this Article XIV.

**XIV.C. RELEASES**

Each member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article XIV. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article XIV.

**XIV.D. CONFIDENTIALITY OF INFORMATION**

XIV.D.1. GENERAL

a. All reports, findings, proceedings and data relating to the evaluation or improvement of the quality of care rendered in the Hospital are confidential and privileged, and are not subject to discovery or introduction into evidence in any civil action.

b. No person in attendance at any committee meeting or other proceeding pursuant to the activities described in Section XIV.B. of these Bylaws shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the meeting.
or proceeding or as to any findings, recommendations, evaluations, opinions, or other actions taken at such a meeting or proceeding.

XIV.D.2. BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of committees, except in conjunction with other Hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

XV. MEDICAL RECORDS

XV.A. The following requirements apply to the inpatient and outpatient history and physical examination:

1. The inpatient history and physical shall contain the following:
   a. chief complaint
   b. initial diagnosis
   c. proposed procedure if applicable
   d. description of allergies
   e. description of the present illness
   f. relevant past medical, social and family history
   g. listing of current medications
   h. comprehensive current physical assessment to include review of major body systems
   i. assessment
   j. plan of care

2. An outpatient history and physical is required for invasive or high risk procedures. The outpatient history and physical shall include the following:
   a. chief complaint
   b. initial diagnosis
   c. proposed procedure
   d. description of allergies
   e. relevant past medical history
   f. listing of current medications
   g. current physical assessment

3. When the history and physical examination is performed and reported by a medical student, resident, fellow, other preceptee or member of the Allied Health Professional Staff, the attending physician shall document supervision by co-signing the history and physical upon the attending physician’s next visit to the patient.

4. Patients admitted for dental care are the dual responsibility of the dentist and a physician member of the Medical Staff with admitting privileges, and shall receive the same basic medical appraisal as patients admitted for other services. This includes an admission history and
physical examination and an evaluation of the overall medical risk, with documentation of the findings in the medical record. The dentist is responsible for a detailed dental history and physical as outlined in hospital approved guidelines, a detailed description of the exam of the oral cavity, and a preoperative diagnosis.

5. Patients admitted for podiatric care are the dual responsibility of the podiatrist and a physician member of the Medical Staff with admitting privileges, and shall receive the same basic medical appraisal as patients admitted for other services. This includes an admission history and physical examination and an evaluation of the overall medical risk, with documentation of the findings in the medical record. The podiatrist is responsible for a detailed podiatric history and physical as outlined in hospital approved guidelines, a detailed description of the exam of the affected area, and a preoperative diagnosis.

6. A history and physical examination shall be completed and on the chart within 24 hours after admission and prior to the performance of surgery. In cases of emergency surgery, the history and physical examination shall be performed and documented as soon as possible after admission. If the admitting physician has performed a complete history and physical up to 30 days prior to admission, a copy of the history and physical may be used in the patient’s medical record. In addition, the physician must also provide and update to the patient’s condition in the progress note prior to surgery or procedure.

7. If the patient is going to surgery within the first 24 hours of admission, the update to the patient’s condition and pre-anesthesia assessment could be accomplished as a combined activity.

8. For obstetrical admission, the entire prenatal record can be used as the history and physical, with an entry no later than 30 days before the inpatient admission. An interim note must also be entered in the progress notes within 24 hours of admission or prior to surgery (if applicable).

9. In an emergency, when there is not time to record the complete history and physical examination, a progress or admission note describing a brief history, appropriate physical findings, and the preoperative diagnosis is recorded in the medical record prior to surgery.

10. When a consult that contains all the elements of a comprehensive history and physical is to be used as the history and physical for a surgical patient, the attending primary surgeon must dictate the surgical-specific portion of the history and physical and refer to the consultation for the balance of the document. A consult over 30 days old falls into the category of an over 30 day old history and physical, and a new history and physical must be dictated.

XVI. RULES AND REGULATIONS AND POLICIES OF THE MEDICAL STAFF

XVI.A. The Medical Staff shall adopt such Rules and Regulations and Policies as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board of Trustees.
XVI.B. These Rules and Regulations and Policies shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each practitioner in the Hospital.

XVI.C. Rules and Regulations shall be a part of these Bylaws, except that new Rules and Regulations may be proposed, or existing Rules and Regulations may be amended or repealed,
   a. at any regular meeting of the Medical Staff at which a quorum is present, and without previous notice, or
   b. at any special meeting on notice, by a two-thirds (2/3) vote of those members of the active Medical Staff with voting privileges who are present, or
   c. via written ballot or email vote

Policies shall be part of these Bylaws except that they may be proposed, approved and/or amended at any meeting of the Medical Executive Committee, or in the same manner as Rules and Regulations. Comments may be submitted if any Medical Staff member who is eligible to vote on the Rule, Regulation or Policy, cannot be present at the meeting at which the proposed Rule, Regulation or Policy will be acted on.

XVI.D Rules, Regulations and/or Policies, or amendments thereto, shall become effective upon approval by the Board of Trustees. Neither body (Medical Staff or Board of Trustees) may unilaterally amend the rules and regulation of the Medical Staff.

XVI.E. Communication of Rules, Regulations, Policies Before Transmission To Board.

1. Rules, Regulations and/or Policies, or amendments thereto, proposed and approved by the Medical Staff pursuant to Section XV.C.1.b or c, above, shall be communicated to the Medical Executive Committee prior to being transmitted to the Board for consideration. If the Medical Executive Committee adopts a policy or an amendment to any policy, such adoption shall be communicated to the Medical Staff prior to the policy or amendment being transmitted to the Board for approval.

2. If the Medical Executive Committee provides a written objection to a Bylaw adopted pursuant to Section XVI.A.2, without a Medical Executive Committee report, or a Rule, Regulation, Policy or amendment adopted by the Medical Staff Section XV.C.1.b or c, within five (5) days of receipt to the Medical Staff, such Bylaw, Rule, Regulation or amendment shall not be transmitted to the Board. Each of Medical Staff and Medical Executive Committee shall appoint three (3) members to a Reconciliation Committee. The Reconciliation Committee shall meet and in good faith discuss each parties’ concerns, both those of the Medical Staff prompting the Bylaw, Rule, Regulation, Policy or amendment, and those of the Medical Executive Committee prompting the objection, and agree on a version of the Bylaw, Rule, Regulation, Policy or amendment to transmit to the Board. If agreement cannot be reached within five (5) days of the written objection being received, the Bylaw, Rule, Regulation, Policy or amendment shall be transmitted to the Board as originally approved by the Medical Staff.
XVII. AMENDMENTS TO THE BYLAWS

XVII.A. AMENDMENT BY ACTIVE STAFF
1. These Bylaws may be amended by those Medical Staff members entitled to vote.

2. A Bylaws amendment may be discussed at any regular or any special Medical Staff meeting provided that a copy of the proposed amendment(s) as approved by the Medical Executive Committee has been distributed to each member entitled to vote at least fifteen (15) days in advance of such meeting. If the Medical Executive Committee fails to report on the proposed amendment within ninety (90) days of receipt of a request for a Bylaws amendment, the Medical Staff shall discuss the proposed amendment absent a recommendation of the Medical Executive Committee at the next regular or special Medical Staff meeting, provided that the Bylaws amendment(s) has been distributed to all members entitled to vote fifteen (15) days in advance of said meeting.

3. Some proposed bylaws amendments are initiated for the purpose of compliance with accreditation standards or regulations. Some amendments are initiated for simple clarification of these bylaws. Some amendments may appear to have no significant controversy for the Medical Staff at large. In these circumstances, the Medical Executive Committee may elect, by unanimous consent of the Medical Executive Committee members present and voting, to bypass the presentation of the proposed bylaws amendments at a Medical Staff meeting as described in Section XVII.A. 2 above. The proposed amendment will then be circulated to the members of the Medical Staff who are entitled to vote as described in section XVII.A.4. If five (5) or more of the Medical Staff members who are eligible to vote, object to voting on the amendment without prior discussion at a Medical Staff meeting, voting will be suspended, and the proposed amendment will be presented at the next regular Medical Staff meeting or at a special meeting of the Medical Staff in accordance with Section XVII.A.2 above.

4. Vote. A Bylaws amendment will be voted on by members of the active Staff entitled to vote via written ballot circulated to the Medical Staff following the regular or special Medical Staff meeting in which the proposed amendment was discussed, or via written ballot absent discussion at a Medical Staff meeting under those circumstances described in Section XVII.A.3 above. At the discretion of the Chief of Staff, a proposed bylaws amendment may also be voted upon at the meeting in which it is discussed as long as a quorum of members eligible to vote are present. In this circumstance, the intention to vote on a given amendment shall be indicated in the meeting packet, which is distributed prior to the meeting. A Medical Staff member who is eligible to vote may submit an absentee ballot prior to the meeting.

5. An amendment shall require a vote of approval by two-thirds (2/3) of those active Medical Staff members voting, provided that at least a quorum (50%) of the active Medical Staff, who are eligible to vote, votes on the amendment. This vote shall be conducted by a written ballot, which may be hand-delivered to the boxes or offices of the active Medical Staff, sent by regular mail, emailed, or sent by facsimile. At the discretion of the Chief of Staff, the vote on the amendment may be taken at the meeting at which it is presented, as outlined in section XVII.A.4 above.

6. Approval by Board of Trustees. Amendments approved by a vote of the Medical Staff shall be effective only when approved by the Board of Trustees.

Approved by General Medical Staff: December 18, 2014
Approved by Board of Trustees: January 28, 2015
7. Provisional amendment for compliance with accreditation standard, law or regulation. The Medical Executive Committee may, by unanimous consent of the Medical Executive Committee members present and voting at a regular or special meeting or the Medical Executive Committee, introduce, discuss, vote on and provisionally approve new Bylaws or amendments initiated only for the purpose of compliance with an accreditation standard, law or regulation, and transmit such provisionally approved Bylaw(s) or amendments to the Board for its provisional approval, without prior approval of the Medical Staff of the Bylaw or amendment as set out in Section XVI.A.4. Such provisional approval of a Bylaw or amendment shall be effective only until the next special or regularly scheduled meeting of the Medical Staff.

XVII.B. AMENDMENT BY THE BOARD OF TRUSTEES

These Bylaws may be amended by the Board of Trustees at any regular or special meeting of the Board of Trustees. A copy of any proposed amendment(s) to these Bylaws shall be distributed to each member of the Medical Executive Committee at least thirty (30) days in advance of the meeting at which the Board of Trustees proposes to take final action thereon. If a majority of the members of the Medical Executive Committee are in disagreement with the proposed amendment(s), the matter shall be referred to the Joint Conference Committee for further study and recommendation before final action is taken by the Board of Trustees. Any amendment(s) to these Bylaws adopted by the Board of Trustees shall become effective when notice is given to the Medical Staff.

XVII.C. UNILATERAL AMENDMENT

Neither the Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Bylaws.

XVII.D. ADMINISTRATIVE

Copies of any approved amendments shall be appended to a master copy of these Bylaws, until such time that they can be inserted into the text of a revised set of Bylaws. The Medical Staff office shall maintain the master copy of the Bylaws, with any attached amendment(s). Copies of the approved amendment(s), or the revised Bylaws, shall be sent to each member of the Medical Staff.

XVII.E. REVIEW AND AMENDMENT

These bylaws may be amended as necessary according to the procedures above. That notwithstanding, the bylaws in their entirety will be reviewed at a minimum every three (3) years with a focus on the following:
1. Compliance with JCAHO standards and other state and federal regulations;
2. Consistency with Medical Staff rules/regulations and policies;
3. Consistency with hospital district bylaws;
4. Consistency with Hospital policies; and

Approved by General Medical Staff: December 18, 2014
Approved by Board of Trustees: January 28, 2015
5. Compatibility with the goals and direction of the Medical Staff as well as the mission, vision and values of the Hospital.

XVIII. ADOPTION OF ST. JOHN'S HOSPITAL BYLAWS OF THE MEDICAL STAFF

XVIII.A. These Bylaws, together with the appended rules and regulations, shall be adopted by a vote of approval by two-thirds (2/3) of those active Medical Staff members voting, provided that at least a quorum (50%) of the active Medical Staff, who are eligible to vote, votes on the adoption, pursuant to Article XVI, and shall replace any previous Bylaws, rules and regulations, and shall become effective when approved by the Board of Trustees of the Hospital. Such approval shall not be unreasonably withheld.

XVIII.B. These Bylaws have been revised and adopted by the active Medical Staff of the Hospital and approved by the Board of Trustees.

XVIII.C. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

XVIII.D. ADOPTED by the Medical Staff on this 18th day of December, 2014, as per documentation in the meeting minutes.

APPROVED by the Board of Trustees on this 28th day of January, 2015, as per documentation in the meeting minutes.
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Approved by General Medical Staff: December 18, 2014
Approved by Board of Trustees: January 28, 2015
February 2007  III.B.2
February 2007  III.C.1.e
February 2007  III.C.2
February 2007  X.D
July 2007  II.B.1
July 2007  II.E.5
July 2007  VI.D.1
July 2007  VII.B.4
July 2007  XI.B.1.e
July 2007  XVI.A
January 2008  XI.B.8
February 2008  II.D
February 2010  VI.D.2
February 2010  XI.C.1
February 2010  XI.A.8
February 2010  XII.C
February 2010  XV (new section)
January 2011  Preamble
January 2011  VI.F (new section)
January 2011  XVI.C
January 2011  XVI.D
January 2011  XVI.E (new section)
January 2011  XVII.A.7 (new section)
January 2011  XVII.B
November 2011  Preamble
November 2011  Definitions
November 2011  II. (multiple revisions)
November 2011  III (major revisions)
November 2011  V (major revisions)
November 2011  VI (major revisions)
November 2011  XVII.C
September 2012  III.B.3.2
September 2012  Delete VIII.G
October 2012  XI.B.1
January 2013  V.C.2.a
January 2013  VI.E.12 (reinstated section)
January 2015  VII.D.3; Addition of Repeated Substantiated Reports Section