MEDICAL STAFF BYLAWS

KISHWAUKEE COMMUNITY HOSPITAL

DEKALB, ILLINOIS

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MEDICAL STAFF BYLAWS

ARTICLE ONE

DEFINITIONS, STATUTORY IMMUNITY,
INTEGRATION AND INTERPRETATIONS

1.1 Definitions. Whenever used in these Bylaws, the terms set forth below shall have the meanings stated unless the context should clearly require otherwise.

1.1.1 The **"Act"** means the Health Care Quality Improvement Act of 1986, Title IV of Public Law 99-660, codified at 42 U.S.C. 11101 *et seq*., and the rules and regulations promulgated thereunder, as amended from time to time, or any successor legislation conferring comparable statutory immunity.

1.1.2 **"Allied Health Professionals Credentialing Policy"** means the written policies and procedures describing the requirements and process for credentialing and establishing the scope of Privileges of allied health personnel providing services at the Hospital that are recommended by the Medical Executive Committee and approved by the Governing Board. The Allied Health Professionals Credentialing Policy shall be considered a part of these Bylaws and shall be incorporated by reference herein.

1.1.3 **"Approved Residency"** means a residency program accredited by: (a) the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association, if Practitioner is a Physician; (b) the Council on Podiatric Medical Education of the American Podiatric Medical Association, if Practitioner is a Podiatrist; or (c) the American Dental Association Commission on Dental Accreditation, if Practitioner is a Dentist or Oral and Maxillofacial Surgeon. With respect to graduates of foreign medical education programs, "Approved Residency" means a program that the Practitioner demonstrates is substantially equivalent to ACGME standards.

1.1.4 **"Board Certified"** or **"Board Certification"** means certification by a board that is: (a) member of the American Board of Medical Specialties or approved by the Specialty Board of the American Osteopathic Association, if Practitioner is a Physician; (b) approved by the Joint Commission on the Recognition of Specialty Boards of the Council on Podiatric Medical Education of the American Podiatric Medical Association, if Practitioner is a Podiatrist; or (c) recognized by the American Dental Association Council on Dental Education and Licensure, if Practitioner is a Dentist or an Oral and Maxillofacial Surgeon. Notwithstanding any other provision of these Bylaws a Medical Staff member who was appointed to the Medical Staff prior to March 22, 1999 may be reappointed to the Medical Staff after March 22, 1999, regardless of his or her Board Certification status, so long as he or she meets all other qualifications for Medical Staff membership.

1.1.5 **"Bylaws"** means the Bylaws of the Medical Staff of the Hospital adopted by the Medical Staff and the Governing Board and includes: (a) the provisions of this document; (b) the Rules and Regulations; (c) the Medical Staff Code of Conduct; and (d) the Allied Health Professionals Credentialing Policy. All such documents are hereby

incorporated by reference and shall be an integral part of these Bylaws, applicable, in accordance with their terms, to all members of the Medical Staff.

1.1.6 **"Chief Executive Officer"** means the President and CEO of Kish*Health* System.

1.1.7 "**CMO" or "Chief Medical Officer**" means the Chief Medical Officer of the Kish*Health* System.

1.1.8 **"Clinical Privileges"** or **"Privileges"** means the permission recommended by the Medical Staff and granted by the Governing Board to a Practitioner to provide specifically delineated diagnostic, therapeutic, medical or surgical services at the Hospital.

1.1.9 **"Credentials Committee"** means the credentials committee of the Medical Staff. The Credentials Committee, and any of its subcommittees, are "Professional Review Bodies" within the meaning of Section 431(11) of the Act.

1.1.10 **"Conflict of Interest"** for the purposes of these Bylaws shall include, but not solely be limited to, a person who: (a) is a family member or business associate to the Practitioner; (b) is in full and active professional economic competition with the Practitioner (other than merely being a member of the same medical specialty or a Practitioner holding the same Clinical Privileges); (c) has previously been involved in professional disputes with the Practitioner; or (d) because of his or her circumstances or position, is deemed by the Chief of Staff or chair of a Medical Staff committee to have a conflict.

1.1.11 **"Dentist"** means an individual possessing the degree of doctor of dental surgery or doctor of medical dentistry who is licensed by the Illinois Department of Professional Regulation to practice dentistry as provided in the Illinois Dental Practice Act.

1.1.12 **"FPPE"** means Focused Professional Practice Evaluation as further defined by The Joint Commission accreditation standards for Hospital or Hospital and Medical Staff policies and procedures.

1.1.13 **"Good Standing"** means the Medical Staff Practitioner, at the time such standing is determined, at any medical facility operated by the Kish*Health* System: (a) has not received a suspension or curtailment of his or her appointment or Clinical Privileges (other than suspension or curtailment for failure to complete medical records) in the previous twelve (12) months; (b) is not currently exercising Clinical Privileges under a monitoring agreement with the Hospital, the Medical Staff or Medical Staff leadership; (c) has not entered into any other agreement to voluntarily restrict his or her right to apply for Medical Staff membership; (d) has not been denied Medical Staff membership; or (e) has not withdrawn his or her application for Medical Staff membership.

1.1.14 **"Governing Board," "Board of Directors"** or **"Board"** means the Board of Directors of Kish*Health* System, to which the governing board of the Hospital has delegated responsibility for the Hospital's organization, management, control and

operation, including appointment of the Medical Staff. As appropriate to the context and consistent with the Hospital corporate bylaws and delegations of authority made by the Governing Board, it may also mean any individual authorized by the Governing Board to act on its behalf on certain matters. The Governing Board, and any of its subcommittees that address Medical Staff matters, are "Professional Review Bodies" within the meaning of Section 431(11) of the Act.

1.1.15 **"Hospital"** shall mean Kishwaukee Community Hospital.

1.1.16 **"Hospital Representative(s)"** means any persons that have responsibility for collecting and evaluating credentials and acting upon applications for appointments or reappointment or for taking any other action related to the Medical Staff, including without limitation: KHS, the Governing Board, its directors and committees; the Chief Executive Officer, President, the Chief Medical Officer, employees, representatives and agents of the Hospital or KHS; the Medical Staff organization, and all Medical Staff members, officers, committees and committee members or other persons who assist such committees; and any authorized representative of the foregoing; the Medical Staff Quality Committee; and any person assisting any of the above-listed entities, bodies, persons or committees whether or not employed or affiliated with the Hospital.

1.1.17 **"Immunity Provisions"** means any provisions affording the Hospital or a Hospital Representative immunity from civil liability pursuant to the Act, the Hospital Licensing Act (210 ILCS 85/10.2), as amended, and, as applicable, the Medical Practice Act of 1987 (225 ILCS 60/5), as amended, or any successor legislation conferring comparable privileges and immunities.

1.1.18 **"KHS"** means the Kish*Health* System, an Illinois not-for-profit corporation that is the sole corporate member of the Hospital.

1.1.19 **"Medical Executive Committee"** means the executive body of the Medical Staff. The Medical Executive Committee, and any of its subcommittees, are "Professional Review Bodies" within the meaning of Section 431(11) of the Act.

1.1.20 **"Medical Staff"** means all Practitioners who have been duly appointed to membership on the Medical Staff of the Hospital and who have been granted Clinical Privileges to attend patients or to provide other diagnostic, therapeutic, teaching or research services at the Hospital.

1.1.21 **"OPPE"** means Ongoing Professional Practice Evaluation as further defined by The Joint Commission accreditation standards for Hospital or Hospital and Medical Staff policies and procedures.

1.1.22 **"Oral and Maxillofacial Surgeon"** means an individual who: (a) is licensed by the Illinois Department of Professional Regulation to practice dentistry as provided in the Illinois Dental Practice Act; (b) has completed an oral and maxillofacial surgery residency program that has been accredited by the American Dental Association Commission on Dental Accreditation; and (c) is a diplomat of the American Board of Oral

and Maxillofacial Surgery or a fellow or a member of the American Association of Oral and Maxillofacial Surgeons.

1.1.23 **"Physician"** means an individual possessing the degree of doctor of medicine or doctor of osteopathy with an M.D. or D.O. degree, who is licensed by the Illinois Department of Professional Regulation to practice medicine in all its branches as provided in the Medical Practice Act of 1987.

1.1.24 **"President"** means the individual appointed by the Chief Executive Officer as the President of the Hospital to manage the affairs of the Hospital. The President may, consistent with his or her responsibilities under the Hospital corporate bylaws designate a representative to perform his or her responsibilities under these Bylaws.

1.1.25 **"Professional Review Activity"** or **"Professional Review Action"** means any activity or action of the Hospital or a Hospital Representative with respect to an individual Practitioner to: (a) determine whether such Practitioner may be appointed to membership on the Medical Staff or may have Clinical Privileges at the Hospital; (b) determine the scope or conditions of such Privileges or membership; (c) change or modify such Practitioner's Privileges or membership; or (d) evaluate clinical practices for purposes of improving or benefiting patient care and treatment or for purposes of professional discipline including institution of a precautionary suspension.

1.1.26 **"Professional Review Body"** means, as appropriate to the circumstances, the Governing Board, the Medical Executive Committee, the Credentials Committee, or any subcommittee thereof, or any hearing committee designated pursuant to these Bylaws, the Chief Executive Officer, the President, the Chief Medical Officer and any other person, committee or entity which conducts a Professional Review Activity or assists in conducting a Professional Review Activity.

1.1.27 **"Practitioner"** means any Physician, Oral and Maxillofacial Surgeon, Dentist or Podiatrist who either: (a) is applying for appointment to the Medical Staff and for Clinical Privileges; or (b) currently holds appointment to the Medical Staff and exercises specific delineated Clinical Privileges; or (c) is applying for or is exercising temporary Clinical Privileges pursuant to the requirements for temporary Clinical Privileges as delineated in these Bylaws.

1.1.28 **"Podiatrist"** means an individual possessing the degree of doctor of podiatric medicine or doctor of surgical chiropody who is licensed by the Illinois Department of Professional Regulation to practice podiatry under the Podiatric Medical Practice Act of 1987.

1.1.29 **"Rules and Regulations"** means the written policies of the Medical Staff that are promulgated by the Medical Executive Committee and approved by the Governing Board to implement more specifically the general principles of conduct found in these Bylaws.

1.1.30 **"Third Party"** or **"Third Parties"** means all individuals, including Medical Staff members, employees or agents of other hospitals, or other physicians or

health practitioners, nurses or other organizations, associations, partnerships and corporations that are unaffiliated with Hospital, or government agencies. The definition of Third Parties shall include all individuals or entities providing information to Hospital or Hospital Representatives whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or Hospital Representatives.

1.2 Statutory Immunity. The Hospital or any Hospital Representative(s) that conducts Professional Review Activities, hereby constitute themselves as Professional Review Bodies as defined in the Act and as committees/persons, as applicable, afforded immunity from civil liability under the Immunity Provisions. Each Professional Review Body hereby claims all privileges and immunities afforded to it by said state and federal statutes. Any action taken by a Professional Review Body pursuant to these Bylaws shall be in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the Hospital), only after a reasonable effort has been made to obtain the facts of the matter, after adequate notice and hearing procedures are afforded to Practitioner and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

1.3 Construction of Terms; Headings and Cross References. Words used in these Bylaws will be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision. Throughout these Bylaws, cross-references are made to other Articles of these Bylaws and to other related documents. By reason of amendments, it is possible that cross-references may not always be appropriately changed to conform to the intentions expressed in this or related documents. In such circumstances, such cross-references shall be interpreted as applying to the Article: (a) designated at the time originally drafted, if such Article is still included in the appropriate documents, even though it may have been renumbered or amended; or (b) replacing such cross-referenced Article, if the content of such replacement Article is such as to be consistent with the original sense of the cross-reference.

1.4 Severability Clause. In the event that any provision in these Bylaws shall be determined by a court of law to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired by such a determination.

1.5 Governing Law. These Bylaws shall be governed by, and construed in accordance with, the Act and, to the extent not inconsistent therewith, the Immunity Provisions and the other laws of the State of Illinois without giving effect to its conflict of laws principles.

1.6 Counting of Days. In any instance in which the counting of days is required in these Bylaws in connection with the giving of a notice or for any other purpose, the day of the event shall not count, but the day upon which the notice is given shall count. In any case where the date on which some action is to be taken, notice given or period expiration occurs on a holiday, Saturday or Sunday, such action shall be taken, such notice given or such period extended to the next succeeding Monday, Tuesday, Wednesday, Thursday, or Friday which is

not a holiday. For the purposes of this Article, the term "holiday" shall mean such days as are commonly recognized as holidays by the United States Federal Government.

1.7 Notices. Except as otherwise provided herein, all notices, requests, demands, reports, written statements and other communications required or permitted to be given to or by a Practitioner pursuant to these Bylaws shall be in writing and shall be deemed to have been duly given, when: (a) delivered personally; (b) delivered by overnight courier (costs prepaid); (c) sent by facsimile with confirmation of transmission by the transmitting equipment; (d) sent by e-mail if the Practitioner has indicated such method of notice is acceptable to him or her in his or her most recent membership application; or (e) received or rejected by a Practitioner or the Hospital, if sent by United States certified or registered mail, postage paid, return receipt requested, with respect to the Practitioner, to the address listed on his or her most recent membership application or to his or her last known address according to the books and records of the Hospital, or with respect to the Hospital, to the President. Notice of all regular Medical Staff meetings and committee meetings shall be deemed properly given if posted or distributed through inter-Hospital mail or on the Physician website.

1.8 Confidentiality and Reporting. Actions taken and recommendations made pursuant to these Bylaws shall be treated as confidential in accordance with such policies regarding confidentiality as may be adopted by the Governing Board. The Chief Executive Officer, Chief Medical Officer, or the President shall make such reports to governmental agencies or other bodies as are required by the Act, the Hospital Licensing Act or any other applicable federal or state law.

ARTICLE TWO

MEDICAL STAFF PURPOSE; RESPONSIBILITIES; AND MEDICAL STAFF YEAR

2.1 Purposes.

2.1.1 The Hospital is a nonprofit, acute care, short-term general hospital that provides a broad range of medical, surgical, pediatric and obstetric services. Patient service is its first responsibility. Dedication to this responsibility requires the joint efforts of the Practitioners practicing in the Hospital facilities, the Governing Board, the Chief Executive Officer, Chief Medical Officer, and the President, with well-defined lines of communications, responsibility and authority throughout the organizational structure. The Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Governing Board. The laws, regulations, customs and generally recognized professional standards that govern hospitals require that Practitioners practicing at a hospital, except those exercising temporary Privileges, be appointed to the Medical Staff and that the Governing Board grant permission to the Medical Staff to practice in the Hospital and report on the quality, efficiency and overall appropriateness of Practitioner performance.

2.1.2 The Practitioners practicing in the Hospital hereby organize, in accordance with these Bylaws and the Rules and Regulations. These Bylaws, along with

the Rules and Regulations, set forth the framework, principles and procedures by which the Medical Staff is organized, governs itself, carries out its responsibilities consistent with the Hospital's corporate bylaws, policies and rules, and is accountable to the Governing Board. The Governing Board shall approve and comply with these Bylaws and the Rules and Regulations.

2.2 Medical Staff Responsibilities. In furtherance of the purposes identified above, the Medical Staff shall be responsible for the duties and obligations listed below. In fulfilling these responsibilities, the Medical Staff shall be subject to the ultimate authority of the Governing Board.

2.2.1 Provide oversight, through a single organized Medical Staff, of the quality of the care, treatment and professional services provided by Practitioners with Clinical Privileges including, without limitation, ensuring that all pertinent precautions for the safety and welfare of patients treated in the Hospital are taken.

2.2.2 Participate in performance improvement activities designed to maintain and improve the quality and efficiency of medical care provided by Practitioners with Clinical Privileges including, without limitation, facilitating the Hospital's quality review, utilization management, professional liability prevention, patient safety programs and continuing education.

2.2.3 Establish a Hospital specific mechanism for making decisions and recommendations regarding appointment and reappointment of Medical Staff members, the granting and renewal/revision of Clinical Privileges and corrective action.

2.2.4 Establish a framework, through these Bylaws, for self-governance of Medical Staff activities and accountability to the Governing Board and for enforcing and complying with these Bylaws.

2.2.5 Develop and implement a process of evaluation and delineation of Clinical Privileges at the time of appointment to the Medical Staff and for reappraisal of Clinical Privileges prior to reappointment to the Medical Staff and assure that all Practitioners with Clinical Privileges provide services within the scope of Clinical Privileges granted.

2.2.6 Establish a mechanism for assisting Medical Staff members in addressing physical and mental health problems.

2.2.7 Provide an effective means of communication between members of the Medical Staff, the President, the Governing Board and the community that the Hospital serves.

2.2.8 Conduct and monitor medical education activities within the Hospital.

2.2.9 Provide input to the Hospital in connection with the Hospital's long-range planning activities, assist in identifying community health needs and participate in

developing and implementing appropriate institutional policies and programs to meet those needs.

2.2.10 Exercise, through its officers, committees and other defined components, the authority granted by these Bylaws to fulfill these responsibilities in a timely and proper manner and to account thereon to the Governing Board.

2.3 Medical Staff Year. For purposes of these Bylaws, the Medical Staff year shall be May 1 through April 30.

ARTICLE THREE

MEDICAL STAFF QUALIFICATIONS AND MEMBERSHIP

3.1 General Qualifications for Membership. To be eligible and remain on the Medical Staff, every Practitioner must, at the time of application, initial appointment and thereafter, demonstrate to the Medical Executive Committee and the Governing Board that he or she possesses, continually, the core competencies outlined below in this Article 3.1, that:

3.1.1 The Clinical Privileges he or she requests are consistent with any Medical Staff plan approved by the Governing Board;

3.1.2 He or she possesses the background, experience and training and demonstrated competence that assures, in the sole judgment of the Governing Board, any patient treated by him or her in the Hospital will be given quality medical care; and

3.1.3 He or she possesses the minimal qualifications set forth in these Bylaws and any additional qualifications and procedural requirements as are determined by the Medical Staff or set forth in other provisions of the Bylaws, as may be amended from time to time.

3.2 Patient Care. The Practitioner provides patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life, as evidenced by the following:

3.2.1 The Practitioner provides his or her patients with continuous care at the generally recognized professional level of competency and efficiency.

3.2.2 The Practitioner provides for continuity of patient care and, in his or her absence or unavailability, delegates or arranges for appropriate and timely diagnosis or care of patients by a Practitioner who is qualified to undertake this responsibility.

3.2.3 The Practitioner seeks consultation whenever appropriate.

3.2.4 The Practitioner does not practice medicine unless and until he or she is free from any physical or mental condition that may impair his or her ability to exercise Clinical Privileges or to care for patients, including, but not limited to, substance abuse.

3.2.5 The Practitioner provides call coverage to Hospital patients as required by Hospital or Medical Staff schedules, policies and procedures.

3.2.6 The Practitioner conducts any clinical research in accordance with applicable local, state and federal laws and regulations and Hospital policies and procedures.

3.2.7 To the extent required per his or her Medical Staff category designation, the Practitioner maintains a principal office within 30 minutes of the Hospital during typical driving conditions.

3.2.8 To the extent required per his or her Medical Staff category designation, the Practitioner is able to arrive at the Hospital when responsible for patient care within 30 minutes during typical driving conditions.

3.2.9 The Practitioner refrains from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised and/or who is not employed or otherwise credentialed by the Hospital.

3.2.10 Payment of Medical Staff dues within sixty (60) days from the date of the dues notice is a requisite of Medical Staff membership. If Medical Staff have not paid dues fourteen (14) days prior to due date, one reminder will be sent to them.

3.3 Medical/Clinical Knowledge. The Practitioner demonstrates knowledge of established and evolving biomedical, clinical and social sciences, and evidences the application of this knowledge to patient care and the education of others, through or by:

3.3.1 Holding at all times a currently valid and unrestricted license issued by the State of Illinois to practice medicine, dentistry or podiatry. Failure to maintain this qualification shall be deemed to be an automatic voluntary relinquishment of Practitioner's Medical Staff membership under Article Twenty of these Bylaws.

3.3.2 Holding at all times, to the extent applicable, a valid and unrestricted Drug Enforcement Administration registration and an Illinois Controlled Substance License. Failure to obtain and maintain this qualification shall be deemed to be an automatic voluntary relinquishment of Practitioner's Medical Staff membership under Article Twenty-one of these Bylaws.

3.3.3 Being a graduate of an accredited medical, osteopathic, podiatric or dental school and be a qualified practitioner of medicine, osteopathy, podiatry or dentistry, completing an Approved Residency, having appropriate training, current experience, clinical results, and utilization practice patterns, and documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency.

3.3.4 Pursuing such continuing education activities as are required by the Illinois Medical Practice Act and the Illinois Department of Financial and Professional

Regulation, Division of Professional Regulation (hereinafter "Division of Professional Regulation").

3.3.5 Obtaining and maintaining Board Certification in the appropriate medical specialty. Practitioners must possess the necessary qualifications to take the qualifying examination of the specialty in which he/she seeks Board Certification and must take and pass this examination as per their college/academy recommendation. Should a Medical Staff Member not achieve certification prior to his/her board certification expiration, he/she would be allowed continued membership through the reappointment period that included the next available board examination date and results period. If a lapse in certification occurs, the Practitioner must supply a recertification plan with dates of exam and results period to the MEC at their next regularly scheduled meeting. Failure to this supply the MEC with such information and failure achieve recertification within the time frame provided by the Practitioner and approved by the MEC shall automatically be deemed a voluntary relinquishment of Practitioner's Medical Staff membership under Article of this Policy. Notwithstanding any other provision of these Bylaws or the Credentialing Policy, Medical Staff members who were appointed to the Medical Staff prior to March 22, 1999 may be reappointed to the Medical Staff, regardless of their Board Certification status, after March 22, 1999, so long as all other qualifications for Medical Staff membership are met.

3.4 Practice-Based Learning and Improvement. The Practitioner is able to use scientific evidence and methods to investigate, evaluate and improve patient care as demonstrated by his or her:

3.4.1 Participation in Professional Review Activities, as requested by the Medical Staff or the Hospital.

3.4.2 Compliance with Medical Staff or Hospital requests for peer review information.

3.4.3 Acceptance of Medical Staff committee assignments and such other reasonable duties and responsibilities related to evaluating and improving patient care delivered at Hospital.

3.4.4 Capacity to adjust practice patterns and satisfactorily treat patients as indicated by the results of the Hospital or Medical Staff quality assessment activities or acceptable standards of care.

3.5 Interpersonal and Communication Skills. The Practitioner demonstrates interpersonal and communication skills that enable him or her to establish and maintain professional relationships with patients, families, and other members of the health care team and complies at all times with the Medical Staff Code of Civility and Disruptive Provider Policy, as evidenced by the following:

3.5.1 The Practitioner continually demonstrates the ability to work cooperatively with others in the Hospital environment and refrains from conduct of disruption as defined by the Disruptive Provider Policy.

3.5.2 The Practitioner communicates in writing and verbally in an intelligible manner with Hospital, Medical Staff, other members of the care team, patients and families.

3.5.3 The Practitioner prepares medical record entries and other required documentation in a legible and timely manner as required by the Bylaws, Rules and Regulations, and other applicable policies of the Medical Staff or Hospital.

3.6 Professionalism. The Practitioner demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward patients, the medical profession and society, as evidenced by Practitioner:

3.6.1 Being of acceptable professional and moral character and abiding by generally recognized ethical principles.

3.6.2 Continuously complying with the Bylaws, Rules and Regulations, Medical Staff Code of Civility, and Medical Staff or applicable Hospital policies and procedures, including, without limitation, appropriately discharging all Medical Staff and Hospital functions for which he or she is responsible.

3.6.3 Maintaining in strict confidence all information related to Professional Review Activities.

3.6.4 Conforming his or her conduct to the requirements of the Medical Staff Code of Civility and refraining from behavior that is "disruptive" as defined by the Disruptive Provider Policy.

3.6.5 Appearing before the Medical Executive Committee in connection with any Medical Staff disciplinary or investigative action when requested.

3.6.6 Being truthful and accurate, fully disclosing all pertinent facts and circumstances known to the Practitioner, in all written or oral communications to the Medical Staff, Hospital, any Medical Staff or Hospital committee or Professional Review Body.

3.6.7 Abstaining from fee splitting or other unlawful financial inducements relating to patient referral.

3.6.8 Refraining from deceiving patients as to the identity of any individual providing treatment.

3.6.9 Immediately reporting to the President and/or Chief Medical Officer, by telephone and in writing, the following:

(a) Receipt of any notice of restriction, condition, or probation on or loss of his or her license to practice medicine, dentistry or podiatry in any state or Practitioner's Drug Enforcement Administration registration or any state controlled substance license.

(b) Receipt of any notice of actual or proposed exclusion from any federally-funded health care program.

(c) Any felony conviction and any misdemeanor conviction involving controlled substances, health care, violence or moral turpitude and provide to the President and/or the Chief Medical Officer a copy of the Judgment of Conviction as soon as practicable.

(d) Receipt of treatment for a physical or mental health condition that may affect Practitioner's ability to provide medical care to patients.

(e) Reporting to the President and/or the Chief Medical Officer, by telephone and in writing within the time frame established by the Health Care Professional Credentials Data Collection Act or applicable Hospital or Medical Staff policy, the following:

(i) New or updated information that is pertinent to any question on the Medical Staff application form, including, without limitation, entering into a monitoring or other type of voluntary agreement with the medical staff of another facility or any other change in Practitioner's Medical Staff membership at another health care facility, voluntary or involuntary.

(ii) Any voluntary or involuntary relinquishment or termination of medical staff appointment or clinical privileges at any other hospital.

(f) Reporting in writing to the President and/or the Chief Medical Officer within 30 days of receipt of notification that an adverse action report or medical malpractice payment report has been filed with the National Practitioner Data Bank.

(g) Complying with any limitations or special conditions on Practitioner's Clinical Privileges imposed by the Medical Staff.

(h) Executing all authorizations and acknowledgements required by these Bylaws.

3.7 Systems-Based Practice. The Practitioner demonstrates both an understanding of and the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care delivery at Hospital and in the community, as demonstrated by the following:

3.7.1 Maintaining continuous professional liability insurance designating the Hospital as a certificate holder through an insurer that is acceptable to the Hospital and either licensed or approved by the Illinois Department of Financial and Professional Regulation, Division of Insurance with coverage amounts that are consistent with the coverage requirements established by the Governing Board and obtaining adequate tail coverage upon the occurrence of an event that results in the need for tail coverage. Failure to maintain such required insurance automatically shall be deemed an automatic voluntary relinquishment of Practitioner's Medical Staff membership and Clinical Privileges under Article Twenty of these Bylaws.

3.7.2 Providing proof of a 2-step tuberculosis skin screen for new Practitioners to staff, and documentation of mumps, rubella and rubeola immunity. Management of positive reactors will be in accordance with the Hospital positive reactor procedure. Individuals with a history of BCG vaccination will be treated as positive reactors according to the Center of Disease control guidelines. Further testing will take place in the event of an exposure to a positive TB patient. Failure to obtain and maintain this qualification may be deemed an automatic voluntary relinquishment of Practitioner's Medical Staff membership and Clinical Privileges under Article Twenty of these Bylaws.

3.7.3 Utilizing the Hospital's facilities for patients in a manner that is consistent with the services offered by the Hospital.

3.8 Effect Of Other Affiliations. No Practitioner shall be automatically entitled to appointment or to the exercise of particular Clinical Privileges merely because he or she is: (a) licensed to practice in this or any other state; (b) a member of any professional organization; (c) certified by any clinical board; (d) a member of a medical or other professional school faculty; or (e) had, or presently has, medical staff appointment or clinical privileges at another health care facility or in another practice setting. No Practitioner shall be automatically entitled to reappointment or renewed Clinical Privileges at the time of reappraisal merely because he or she had, or presently has, Medical Staff membership or particular Clinical Privileges at this Hospital or holds an administrative position with the Hospital.

3.9 Nondiscrimination; Uniform Applicability of Requirements. No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of: age; sex; race; creed; color; national origin; sexual orientation, a handicap unrelated to the ability to fulfill patient care and required Medical Staff obligations; or, any other criterion unrelated to the delivery of quality patient care, in an efficient manner that meets the standards of Practitioner's professional qualifications, the advancement of the Hospital's purposes, the Hospital's or community's needs, or the Hospital's demonstrated capabilities. The qualifications for Medical Staff membership and Clinical Privileges set forth in these Bylaws shall be uniformly applied to all Practitioners who are granted an application for appointment to the Medical Staff.

3.10 Term of Appointment. Appointments to the Medical Staff and grants of Clinical Privileges are for a period not to exceed 24 months.

3.11 Exceptions To Two-Year Appointment. The following are exceptions to the 24-month appointment period:

3.11.1 The Governing Board may, after considering the recommendations of the Medical Executive Committee, set a more frequent reappraisal period for the exercise of particular Clinical Privileges in general.

3.11.2 Corrective action involving Medical Staff membership status and/or Clinical Privileges may be initiated and taken in the interim under the appropriate provisions of these Bylaws.

3.11.3 In the case of a Practitioner providing professional services to the Hospital by contract/employment, termination or expiration of the contract/employment

may result in a shorter period of Medical Staff appointment or Clinical Privileges if that is the effect required by the contract/employment arrangement or under the Bylaws.

ARTICLE FOUR

INITIAL APPOINTMENT PROCEDURES

4.1 Pre-Application. Except as otherwise provided herein, all Practitioners seeking an application to the Medical Staff must first complete a pre-application. Such pre-application shall be obtained from the Medical Staff Office . Practitioners on the Medical Staff of other KHS facilities shall not be required to submit a pre-application.

4.1.1 Contents of Pre-Application. Upon written request, a pre-application and a Release of Liability and Practitioner's Statement shall be sent to a Practitioner. These documents must be signed and returned to the Medical Staff Office with the following information:

(a) Practice specialty.

(b) Location (actual or anticipated) of principal office and principal residence.

(c) Names and locations of principal Hospital affiliations over the past five years.

(d) Copy of current, unrestricted license to practice medicine, dentistry or podiatry in the State of Illinois or evidence that the Practitioner has applied for an Illinois license and holds an unrestricted license to practice medicine, dentistry or podiatry, as applicable, in another state.

(e) Copy of current Illinois Controlled Substance License and Federal Drug Enforcement Administration registration, if applicable, or evidence that the Practitioner has applied for an Illinois Controlled Substance License and holds an unrestricted controlled substance license in another state.

(f) Evidence of professional liability insurance coverage that satisfies the requirements of these Bylaws or a detailed explanation of how such coverage requirements will be met; provided, however, that an application shall be incomplete until evidence of such coverage is provided.

(g) Curriculum vitae.

(h) Medical School and Residency diplomas, and to the extent a Practitioner graduated from a foreign medical school, a copy of the Practitioner's Educational Commission for Foreign Medical Graduates certification.

(i) Evidence of Board Certification or, if applicable under Article Three of these Bylaws, eligible to take the Board Certification qualifying examination.

(j) Reason for interest in affiliating with the Hospital and description of anticipated commitment to the community.

4.1.2 Review of Pre-Application. The Hospital shall review the pre-application and, assess whether the Practitioner meets the qualifications for Medical Staff membership set forth in these Bylaws, which determination may include consideration of the needs of the Hospital and the community, utilization patterns, actual and planned allocations of physical, financial, and human resources within the Hospital, the Hospital's strategic plan, the organizational plans for patient care, business plans of individual Hospital clinical service areas and applicable laws and regulations. If, based on this assessment, the Practitioner would be eligible for Medical Staff membership, an application shall be provided to the Practitioner. If, in accordance with this Article, the Practitioner would not be eligible for Medical Staff membership, the Hospital shall notify the Practitioner in writing. No such Practitioner shall be entitled to any procedural rights under these Bylaws.

4.2 Application. If, pursuant to Article 4.1.2 of these Bylaws, the Practitioner receives an application, he or she shall provide a complete and accurate application for Medical Staff appointment shall be submitted to the Medical Staff Office by the Practitioner using the Health Care Professional Credentialing and Business Data Gathering Form approved by the State of Illinois. The Medical Staff Office shall provide all applicants with a copy of these Bylaws and the Rules and Regulations.

4.2.1 Contents of Application. Every Practitioner must furnish, in electronic format specified by the Hospital, a completed application, including any state-mandated application forms. Practitioners also must provide a valid picture ID issued by a state or federal agency, with their completed application. Unless previously submitted as part of the preapplication, the information required in the application includes, but is not limited to the following:

(a) Medical Staff category and specific Clinical Privileges requested.

(b) Undergraduate, medical school, and postgraduate training, including the name of each institution attended, degrees granted, program completed, dates attended, and for all postgraduate training, names of Practitioners responsible for monitoring the Practitioner's performance for verification of Practitioner's relevant training and experience.

(c) Written confirmation that Practitioner has a currently valid and unrestricted license to practice medicine, dentistry or podiatry, as applicable, from the state licensing board.

(d) Written confirmation that Practitioner has completed an Approved Residency.

(e) To the extent applicable, evidence that Practitioner has a valid and unrestricted Drug Enforcement Administration registration and State Controlled Substance License.

(f) Specialty or subspecialty Board Certification, recertification, or, if applicable under Article Three of these Bylaws, eligibility to take the Board Certification qualifying examination.

(g) Documentation of Practitioner's health status and an explanation of any physical or mental condition that could affect the Practitioner's ability to exercise the Clinical Privileges requested or would require an accommodation in order for the Practitioner to exercise the Clinical Privileges safely and competently.

(h) Evidence of current professional liability insurance coverage and information on professional liability history and experience, including the names of present and past insurance carriers. Evidence of adverse settlements and judgments or pending suits shall not, in and of itself, be considered grounds for denial.

(i) A description of any proceedings initiated, pending, or completed involving allegations or findings of professional misconduct.

(j) A description of any proceedings initiated, pending, or completed or any action involving denial, revocation, suspension, reduction, limitation, probation, voluntary and involuntary surrender, or nonrenewability of any of the following:

(i) License or certificate to practice any profession in any state or country.

(ii) Drug Enforcement Administration or other controlled substances license or registration.

(iii) Membership or fellowship in local, state or national professional organizations.

(iv) Faculty membership at any medical or other professional school.

(v) Appointment or employment status, prerogatives, medical staff membership, or clinical privileges at any other hospital, facility, or organization.

(vi) Any instances, in which the Practitioner did not renew, terminated, restricted, limited, or withdrew or failed to proceed with an application for any of the elements listed immediately above in order to foreclose or terminate an investigation or disciplinary or adverse action.

(vii) Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital.

(viii) Any of the following actions pending or taken in connection with professional liability insurance: denial, nonrenewability, cancellation, limitation in coverage, or application of a surcharge.

(ix) Names and locations of any hospital or facility where the Practitioner had or has any association, employment, medical staff membership, clinical privileges, or practice with the inclusive dates of each affiliation and status held.

(x) Any other information requested by Hospital.

4.2.2 Additional Information. The application must also contain the names of professional references as required in 4.2.3 of these Bylaws and executed authorizations and acknowledgements summarizing the scope and extent of the authorization, confidentiality, immunity, and release provisions of these Bylaws.

4.2.3 References. The application must include the names of at least two professional references in the same professional discipline who are not newly associated or about to become partners with the Practitioner in professional practice or personally related to him or her, who have personal knowledge of the Practitioner's current clinical ability and competence, ethical character, health status and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from Hospital or Medical Staff authorities. The named individuals must have acquired the requisite knowledge through recent observation of the Practitioner's professional performance over a reasonable period of time. At least one reference must be from a colleague in the Practitioner's specialty not about to become associated with him or her in practice, and at least one must have had organizational responsibility for the Practitioner's performance. Reference letters will not be accessible to the Practitioner.

4.2.4 Effect of Application The Practitioner must sign the application and in doing so:

(a) Attests to the correctness and completeness of all information furnished and acknowledges that any misstatement in or omission from the application automatically shall be deemed a voluntary withdrawal of such application; or, in the case of a reappointment application, a voluntary withdrawal of such application and, as a result, his or her Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights.

(b) Signifies his or her willingness, if requested, to appear for an interview in connection with his or her application.

(c) Agrees to abide by the terms of the Bylaws and related manuals and other policies of the Medical Staff and those of the Hospital, as they may be amended from time to time, if granted appointment and/or Clinical Privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment and/or Clinical Privileges are granted.

(d) Agrees to maintain an ethical practice and to provide continuous care to his or her patients.

(e) Agrees to immediately notify designated Medical Staff and Hospital officials, *e.g.,* Chief of Staff, Chief Medical Officer and President, of any initial

application change during the course of the appointment period, including, but not limited to, the information provided in accordance with Article Four.

(f) Authorizes and consents to Hospital Representatives consulting with prior associations and/or any other person providing or receiving any information regarding the Practitioner's background, experience, clinical competence, professional ethics, utilization practice patterns, character, health status, and other qualifications performed or made in connection with activities related to the Practitioner's Medical Staff appointment and Clinical Privileges and consents to Hospital Representatives inspecting all records and documents that may be material to evaluation of said qualifications and competence and specifically acknowledges his or her agreement to execute the authorizations as described in these Bylaws.

4.2.5 Processing the Application

(a) Complete Application; Practitioner's Burden.

(i) A Medical Staff application must be complete before it can be processed. Once the application is deemed completed, the application shall be processed promptly. Completion means the following three things:

(ii) All required information and necessary additional explanations have been provided.

(iii) Verification that the application information is complete and the application includes all information necessary to properly evaluate a Practitioner's qualifications and such information has been received and is consistent with the information provided in the application form.

(iv) Responsive letters of reference and information from past hospitals and other affiliations have been received.

(v) The Practitioner has the burden of producing adequate information for a proper evaluation of his or her experience, training, current competence, utilization practice patterns, ability to work cooperatively with others, and health status, and of resolving any doubts about these or any of the qualifications required for Medical Staff appointment or the requested Medical Staff category, or Clinical Privileges, and of satisfying any requests for information or clarification (including health examinations) made by appropriate Medical Staff or Governing Board authorities. The Practitioner shall be responsible for ensuring that all information that he or she provides contains no inaccuracies or misrepresentations or omissions of fact. The Practitioner is also responsible for complying with all updating requirements imposed under Illinois law on state licensure application or credentialing update forms. Failure to provide information within 90 days of Hospital's request shall be deemed a voluntary withdrawal of such application, or, in the case of a reappointment application, a voluntary withdrawal of such application and, as a result, his or her Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights. Any new applicant whose application is voluntarily withdrawn for failure to provide additional requested information must wait a minimum of 180 days before

requesting a new pre-application. In the case of a reappointment applicant, the Practitioner must reapply as a new applicant.

(vi) Any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, may, at the sole discretion of the Hospital, be deemed a voluntary withdrawal of the application, or, in the case of a reappointment application, shall be deemed a voluntary withdrawal of the application and, as a result, his or her Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights. A Practitioner whose application is withdrawn under this Article shall not be permitted to reapply for a period of two years.

4.2.6 Verification of Information. The Practitioner shall submit the application to the Medical Staff office. The Medical Staff Coordinator, working with the Credentials Committee, organizes and coordinates the collection and verification of the references, licensure and other qualification evidence submitted and notifies the Practitioner of any problems in obtaining the information required. This must be a written notice and must indicate the nature of the information the Practitioner is to provide and a reasonable time frame for response. Failure to respond in satisfactory manner by that date shall be deemed a voluntary withdrawal of the application, or, in the case of an applicant for reappointment, shall be deemed a voluntary withdrawal of the reappointment application and, as a result, his or her Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights. Verification shall include, without limitation, the following steps:

(a) Requesting from the director of the Illinois Department of Professional Regulation information concerning the licensure status and any disciplinary action taken against the Practitioner's license to practice medicine, dentistry or podiatry, as applicable.

(b) Requesting from the Secretary of the Department of Health and Human Services or the alternative agency designated by the Secretary information regarding a Practitioner that has been reported to the National Practitioner Data Bank in accordance with the Act.

(c) Submitting a Request for Physician Profile Data from the Federation of State Medical Boards.

(d) Requesting from any medical disciplinary board information held by it pertinent to decisions of the Hospital regarding credentialing of practitioners.

(e) Requesting from any hospital relevant to residency and fellowship training programs, and at least his or her more recent hospital affiliations, specific information and recommendations from peers regarding his or her training and competence in exercising the Clinical Privileges requested, and specifically, for any special or advanced Clinical Privileges the Practitioner may be requesting.

(f) Requesting from any hospital affiliations, specific information concerning activity, disciplinary actions related to quality of care and/or failure to meet clinical service area or Medical Staff standards and restriction or denial of clinical privileges.

(g) Sources of peer recommendations may include:

(i) Any Medical Staff Standing Committee or other committee that conducts quality assessment and improvement activities, the majority of whose members are the Practitioner's peers.

(ii) A reference letter or documented phone conversation(s) about the Practitioner from a peer(s) who is a member of the Hospital's Medical Staff or who is from outside the Hospital, but is knowledgeable about the Practitioner's competency.

(iii) A clinical service area chair who is a peer.

(iv) The Medical Executive Committee, the majority of whose members are the Practitioner's peers.

(h) When collection and verification is accomplished, the Medical Staff Office transmits the application and all supporting materials to the Credentials Committee.

4.3 Credentials Committee Evaluation and Action. Once an application is deemed complete in accordance with Article Four of these Bylaws, members of the Credentials Committee shall review the application, the supporting documentation and all other relevant information available to it. The Credentials Committee may not consider an incomplete application. A member of the Credentials Committee shall attempt to refrain from reviewing an application of a Practitioner within their practice group and will refer the file to another member of the Credentials Committee. The Credentials Committee may, at its sole discretion, conduct an interview with the Practitioner or designate one or two of its members to do so. If the Credentials Committee requires further information, it may defer transmitting its report not more than 60 days, and it must notify the Practitioner and Chief of Staff in writing of the deferral and the grounds. If the Practitioner is to provide the additional information or a specific release/authorization to allow Hospital Representatives to obtain information, the notice to him or her must so state, must be a written notice, and must include a request for the specific data/explanation required or release/authorization required and the time frame for response. Failure to respond in a satisfactory manner by that date shall be deemed a voluntary withdrawal of the application; or, in the case of a reappointment application, shall be deemed a voluntary withdrawal of the reappointment application and, as a result, his or her Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights.

The Credentials Committee shall prepare a written report with recommendations for, and any special limitations on, appointment, Medical Staff category and Clinical Privileges. The Credentials Committee shall transmit its report to the Medical Executive Committee.

4.4 Medical Executive Committee Evaluation and Action.. The Medical Executive Committee shall review the Credentials Committee recommendation and any pertinent information it deems appropriate. After review, the Medical Executive Committee shall take one of the following actions:

4.4.1 Deferral. Action by the Medical Executive Committee to defer the application for further consideration must be followed up within 30 days, with its report and recommendations. The President and/or the Chief Medical Officer shall promptly send the Practitioner written notice, through the Medical Staff office, of an action to defer, including a request for the specific data/explanation or release/authorization, if any, required from the Practitioner and the time frame for response. Failure to respond in a satisfactory manner by that date shall be deemed a voluntary withdrawal of the application; or, in the case of a reappointment application, shall be deemed a voluntary withdrawal of the reappointment application and, as a result, his or her Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights.

4.4.2 Favorable Recommendation. A Medical Executive Committee recommendation that is favorable to the Practitioner in all respects is forwarded, together with supporting documentation, to the Governing Board.

4.4.3 Unfavorable Recommendation. A Medical Executive Committee recommendation that is unfavorable to the Practitioner, either in respect to appointment, Medical Staff category, or to some or all of the requested Clinical Privileges is forwarded to the President and/or the Chief Medical Officer. The President and/or the Chief Medical Officer shall provide the Practitioner written notice of the unfavorable recommendation and the Practitioner's right to the hearing and appeal procedures set forth in Article Twenty of these Bylaws. If the Practitioner does not wish to avail him or herself of the hearing and appeal procedures, the Medical Executive Committee's recommendation is transmitted directly to the Governing Board by the President and/or the Chief Medical Officer for action.

4.5 Governing Board Action on Credentials Matters. As part of any of its actions outlined below, the Governing Board may, at its discretion, conduct an interview with the Practitioner or designate one or more individuals to do so on its behalf. If, as part of its deliberations, the Governing Board determines that it requires further information, it may defer action, but generally for not more than 30 days, except for good cause, and it shall notify the Practitioner and the Chief of Staff in writing of the deferral and the grounds. If the Practitioner is to provide additional information or a specific release/authorization to allow Hospital Representatives to obtain information, the notice to him or her must so state, must be a written notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response. Failure to respond in a satisfactory manner by that date shall be deemed a voluntary withdrawal of the application and an automatic voluntary relinquishment of Practitioner's Medical Staff membership and Clinical Privileges under Article Eight of these Bylaws.

4.5.1 On Governing Board Action on Medical Executive Committee Recommendation: The Governing Board may adopt or reject, in whole or in part, a recommendation or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made back to the Governing Board. If the Medical Executive Committee's subsequent recommendation after referral back is

unfavorable to the Practitioner, it shall be processed as provided in Article Four of these Bylaws.

If the Governing Board's action is favorable to the Practitioner, it is effective as its final decision. If the recommended action of the Medical Executive Committee was favorable, but the Governing Board's action is unfavorable to the Practitioner in any respect, the President and/or the Chief Medical Officer shall inform the Practitioner by written notice, as specified in Article Twenty of these Bylaws and the Practitioner shall be entitled to the hearing and appeal procedures set forth in these Bylaws. In no event shall a Practitioner be entitled to more than one hearing and appeal in connection with a single appointment or reappointment application.

4.5.2 Without Benefit of Medical Executive Committee Recommendation: The following procedure shall be followed if the Governing Board does not receive a recommendation from the Medical Executive Committee within the time frame provided in Article Four of these Bylaws or within any reasonable extension of that time frame resulting from deferral of a recommendation in order to obtain additional data, explanation or a specific release/authorization, or from any other good cause.

The Governing Board may, after notifying the Medical Executive Committee of its intent, including a reasonable period of time for response, take action on its own initiative, employing the same type of information usually considered by the Medical Staff authorities. Favorable or unfavorable action by the Governing Board is effective as the final decision. If the Governing Board's action is unfavorable in any respect, the President and/or the Chief Medical Officer shall inform the Practitioner by written notice and the Practitioner shall be entitled to the hearing and appeal procedures set forth in Article Nineteen of these Bylaws.

4.6 Content of Report and Basis for Recommendations and Actions. Each individual or group providing a recommendation or acting on an application shall have available the full resources of the Medical Staff and the Hospital as well as the authority to use outside consultants as deemed necessary. The report of each individual or group must include recommendations as to approval or denial of, and any special limitations on, Medical Staff appointment, category of Medical Staff appointment and prerogatives, clinical service area affiliation, and Clinical Privileges. All documentation and information received by any individual or group, during or as part of the evaluation process, must be included with the application as part of the individual's central credentials file and, as appropriate or requested, transmitted with reports and recommendations. The reasons for each recommendation or action to deny, restrict or otherwise limit must be stated.

4.7 Conflict Resolution. Whenever the Governing Board determines that it will decide a matter contrary to the recommendation of the Medical Executive Committee, the matter shall be referred to the Medical Executive Committee for reconsideration prior to the Governing Board's final decision.

4.8 Notice of Final Decision.

4.8.1 The President and/or the Chief Medical Officer shall provide written notice to the Practitioner of the final decision of the Governing Board; however, if the decision is negative and is based substantially on economic factors, notice shall be given 15 days before implementation of the decision to practitioner and hospital licensing board.

4.8.2 A favorable decision and notice to appoint includes:

(a) The Medical Staff category to which the Practitioner is appointed;

(b) The Clinical Privileges he or she may exercise; and

(c) Any special conditions attached to the appointment.

(d) For those Practitioners with admitting privileges or who are Hospital-based, a formal Hospital orientation must be completed prior to exercising granted Clinical Privileges.

4.9 Time Periods for Processing. All individuals and groups required to act on an application for Medical Staff appointment must do so in a timely and good faith manner and, except for obtaining required information, Hospital shall use best efforts to ensure that each application is processed within the following time periods:

	INDIVIDUAL/GROUP	TIME
(a)	Medical Staff Office	90 days
(b)	Credentials Committee	Next scheduled meeting after application is deemed complete
(c)	Medical Executive Committee	Next scheduled meeting following Credentials Committee review and recommendation
(d)	Governing Board	Next regular meeting after Medical Executive Committee

These time periods are to be deemed guidelines and are not directives such as to create any rights for a Practitioner to have an application processed within these precise periods. Pursuant to Article Four of these Bylaws, Practitioner has the burden of providing adequate information for evaluation and complying with all updating requirements imposed by the State of Illinois application or update forms. Failure to meet such requirements in a timely manner shall be deemed a voluntary withdrawal of the application; or, in the case of a reappointment application, shall be deemed a voluntary withdrawal of the reappointment application and, as a result, his or her Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights.

If action does not occur at a particular step in the process within the time frame specified and the delay is unwarranted, the President and/or the Chief Medical Officer may immediately proceed to consider the application and all the supporting information or may authorize the application to proceed to the next step.

ARTICLE FIVE

MEDICAL STAFF CATEGORIES

5.1 Categories. There shall be seven (7) categories of appointment to the Medical Staff: Active, Associate, Courtesy, Consulting, Contract, Emeritus and Community Affiliate.

5.2 Limitation of Prerogatives.

5.2.1 General Limitation of Prerogatives. The prerogatives set forth under each Medical Staff category are general in nature and may be subject to the following limitations:

(a) The prerogatives set forth under any Medical Staff category may be limited by special conditions attached to a Practitioner's Medical Staff appointment, by other provisions of these Bylaws or by other policies of the Hospital or Medical Staff.

(b) The prerogative to vote at any Medical Staff meeting or Medical Staff committee, department or section meeting, as set forth under any Medical Staff category, is limited to Medical Staff members that are in Good Standing at the time such vote is taken.

(c) The prerogative of Dentists, Podiatrists and Oral and Maxillofacial Surgeons shall be limited to those for which they have demonstrated the requisite level of medical education, training, experience and ability as determined by resolution of the Medical Executive Committee and approval by the Governing Board.

5.2.2 Waiver of Limitation. In limited circumstances and for good cause, the Chief of Staff, as appropriate to the circumstances, may waive a limitation of prerogatives for a Medical Staff category as applied to a particular Practitioner, with the concurrence of the Chief Executive Officer, Chief Medical Officer, or the President or their designee. Such waiver shall be limited to that specific situation.

5.3 Active Staff.

5.3.1 Qualifications for Active Staff. In addition to meeting the basic qualifications expressly set forth in these Bylaws, to be a member of the Active Staff a Practitioner must satisfy the following requirements:

(a) Regularly admit patients to, or otherwise be regularly involved in the care of patients in the Hospital or demonstrate, by way of other substantial involvement in the activities of the Medical Staff or the Hospital, a genuine concern and interest in the Hospital. For purposes of this Article, "regularly" means that the Practitioner generates a minimum of

twenty-four (24) patient contacts at the Hospital during each two-year term of appointment to the Medical Staff and is otherwise involved in the care of patients in the Hospital. For purposes of this Article a "patient contact" is defined as the admission of any inpatient, the registration of an observation patient, a consultation or the performance of an outpatient surgical procedure.

(b) Have completed, unless specifically exempted, at least two (2) years of satisfactory performance on the Associate Staff.

(c) Maintains a principal office within thirty (30) minutes of the Hospital, during typical driving conditions.

(d) Be able to arrive at the Hospital when responsible for patient care within thirty (30) minutes, during typical driving conditions.

(e) Agree to assume all functions and responsibilities of membership on the Active Staff.

5.3.2 Prerogatives of Active Staff. An active staff member may:

(a) Admit patients in accordance with Practitioner's Clinical Privileges, subject to any limitations imposed by the Medical Staff, the Rules and Regulations or the Hospital's admission policies;

(b) Exercise such Clinical Privileges as are granted to him or her by the Governing Board;

(c) Serve as a Medical Staff officer, department or section chair or Medical Staff committee member or chair, provided he or she satisfies the specific qualifications for the position involved; and

(d) Vote on all matters presented at meetings of the Medical Staff, department(s), section(s) and Medical Staff committees of which he or she is a member.

5.3.3 Responsibilities of Active Staff. An active staff member must, in addition to meeting the basic obligations of Medical Staff appointment, fulfill the following requirements:

(a) Maintain proper quality of medical care and treatment of inpatients and outpatients of the Hospital.

(b) Contribute to the organizational, administrative and medico-administrative (including quality review, professional liability prevention and utilization management) activities of the Medical Staff, including service in Medical Staff matters, departments, sections, as applicable, and on Hospital and Medical Staff committees, faithfully performing the duties of any position to which elected or appointed.

(c) Participate equitably in the discharge of Medical Staff functions by:

(i) Participating in the Hospital's continuing education programs;

(ii) Participating in a rotating on-call system for assignment of patients through the Hospital emergency department, consistent with Clinical Privileges granted by the Governing Board;

(iii) Providing consulting services consistent with his or her Clinical Privileges to other Medical Staff members in a timely fashion, as specified in the Rules and Regulations; provided, however, that the more stringent timing requirement shall apply;

(iv) Actively participate in peer review activities conducted by the Medical Staff and the Hospital; and

(v) Fulfilling such other Medical Staff functions as may reasonably be required.

(d) Attend at least one-half (1/2) of the Medical Staff, Medical Staff committee, department and section meetings, cumulatively within their reappointment cycle, that he or she is requested or required to attend.

(e) Carry out the organization and governance functions of the Medical Staff, including adopting the Rules and Regulations, electing officers and recommending to the Governing Board all appointments and reappointments to the Medical Staff and the granting of Clinical Privileges.

(f) Make recommendations to the Governing Board as necessary and appropriate regarding matters within the purview of the Medical Staff.

5.4 Associate Staff. The Associate Staff category is intended only for those initial applicants to the Medical Staff who seek appointment to the Active Staff. All initial appointees to the Medical Staff who seek appointment to the Active Staff shall be required, before advancement to the Active Staff category, to serve one term of appointment (twenty-four (24) months) as a member of the Associate Staff category of the Medical Staff, during which time such appointee shall be subject to FPPE in accordance with the FPPE policies and procedures of the Hospital and the Medical Staff. Upon the expiration of the initial term of appointment to the Associate Staff, a Medical Staff member shall serve an initial period of twelve (12) months under the direction and evaluation of the Medical Executive Committee. Each Associate Staff member will be considered by the Medical Executive Committee for appointment to the appropriate Medical Staff category, following review of the Physician's first-year activity summary. Associate Staff members shall have the burden to demonstrate that he or she has sufficient clinical competence and activity as noted on the activity profile to justify their appointment to the Active Staff category, or seek appointment to another Medical Staff category; however, if, the Medical Executive Committee determines that an Associate Staff member is reasonably likely to advance to Active Staff, but requires additional time as an Associate Staff member to demonstrate that he or she satisfies the qualifications of Active Staff, then the Medical Executive Committee may extend the term of appointment to the Associate Staff by no more than twelve (12) months, at which time, the appointee must be appointed to the Active Staff or seek

appointment to another Medical Staff category, or he or she will be deemed to have voluntarily relinquished his or her Medical Staff appointment and Clinical Privileges.

5.4.1 Qualifications for Associate Staff. In addition to meeting the basic qualifications expressly set forth in these Bylaws, to be a member of the Associate Staff, a Practitioner must satisfy the following requirements:

(a) Demonstrate a genuine concern and interest in the Hospital through substantial involvement in the activities of the Medical Staff or the Hospital and exercise best efforts to meet the patient contact requirements set forth for active staff in Article 5.3.1.

(b) Maintain a principal office within thirty (30) minutes of the Hospital, during typical driving conditions.

(c) Is able to arrive at the Hospital when responsible for patient care within thirty (30) minutes, during typical driving conditions.

(d) Agree to assume all functions and responsibilities of Medical Staff membership.

5.4.2 Prerogatives of Associate Staff. An Associate Staff member may:

(a) Admit patients in accordance with Practitioner's Clinical Privileges, subject to any limitations imposed by the Medical Staff, the Rules and Regulations or the Hospital's admission policies;

(b) Exercise such Clinical Privileges as are granted to him or her by the Governing Board;

(c) Serve as a member of Hospital or Medical Staff committees but not serve as a Medical Staff officer, a department or section chair or a Medical Staff committee chair; and

(d) Vote on all matters presented at such committee meetings and attend and vote at Medical Staff, department and section meetings.

5.4.3 Responsibilities of Associate Staff. An Associate Staff member must, in addition to meeting the basic obligations of Medical Staff appointment, fulfill the following duties:

(a) Participate in the discharge of Medical Staff functions by:

(i) Serving on Hospital and Medical Staff committees to which he or she is appointed;

(ii) Participating as requested in the quality review, professional liability prevention and utilization management activities required of the Medical Staff;

(iii) Participating in a rotating on-call system for assignment of patients through the Hospital emergency department, consistent with Clinical Privileges granted by the Governing Board;

(iv) Provide consulting services consistent with his or her Clinical Privileges to other Medical Staff members in a timely fashion, as specified in the Rules and Regulations; provided, however, that the more stringent consultant timing requirement shall apply; and

(v) Fulfilling such other Medical Staff functions as may reasonably be required.

(b) Attend at least one-half (1/2) of the Medical Staff, Medical Staff committee, department and section meetings, cumulatively within their reappointment cycle, that he or she is requested or required to attend.

5.5 Courtesy Staff.

5.5.1 Qualifications for Courtesy Staff. In addition to meeting the basic qualifications expressly set forth in these Bylaws, to be a member of the Courtesy Staff, a Practitioner must satisfy the following requirements:

(a) Provide services at the Hospital only on an occasional basis, generating no more than twenty-four (24) patient contacts during each two-year term of appointment to the Medical Staff, unless Practitioner obtains prior approval from the Medical Executive Committee to generate additional patient contacts. For purposes of this Article, "patient contact" is defined as the admission of any inpatient, the registration of an observation patient, a consultation or the performance of an outpatient surgical procedure.

(b) Maintain a principal office within thirty (30) minutes of the Hospital or, with the prior approval of the Medical Executive Committee, designate an alternate to provide coverage if Practitioner's principal office is not located within thirty (30) minutes of the Hospital.

(c) Actively participate in the evaluation and monitoring activities at the Hospital or be a member of the active staff of another hospital where he or she actively participates in patient care, performance evaluation and monitoring activities similar to those required of the Active Staff of the Hospital or provide other documentation of adequate clinical volume and quality outcomes elsewhere so as to provide a basis for the Medical Staff's evaluation of his or her clinical competence.

5.5.2 Prerogatives of Courtesy Staff. A Courtesy Staff member may:

(a) Admit patients in accordance with Practitioner's Clinical Privileges, subject to any other limitations imposed by the Medical Staff, the Rules and Regulations or the Hospital's admission policies;

(b) Exercise such Clinical Privileges as are granted to him or her by the Governing Board;

(c) Attend Medical Staff meetings and applicable department and section meetings but not serve as a Medical Staff officer, a department or section chair or a Medical Staff committee chair; and

(d) Not vote at Medical Staff or department meetings.

5.5.3 Responsibilities of Courtesy Staff. A Courtesy Staff member must, in addition to meeting the basic obligations of staff appointment, fulfill the following duties:

(a) Apply for advancement to Active Staff if the number of patient contacts exceeds that permitted under Article Five of these Bylaws.

(b) If accepting a committee assignment, carry out such assignment in the same manner as required of an Active Staff member, including satisfying such meeting attendance requirements as are applicable.

(c) Provide consulting services consistent with his or her Clinical Privileges to other Medical Staff members in a timely fashion otherwise specified in the Rules and Regulations; provided, however, that the more stringent consultant timing requirement shall apply.

(d) Participate in quality review activities of the Hospital.

5.6 Consulting Staff.

5.6.1 Qualifications for Consulting Staff. Consulting Staff shall consist of Practitioners of recognized professional ability and expertise who are appointed for the specific purpose of providing consultation in the diagnosis and treatment of patients and the administration of clinical services. In addition to meeting the basic qualifications expressly set forth in these Bylaws, to be a member of the Consulting Staff, a Practitioner must be a member of the active staff of another hospital where he or she actively participates in patient care and performance improvement activities similar to those required of the Active Staff of the Hospital or provide other documentation of adequate clinical volume and quality outcomes elsewhere so as to provide a basis the Medical Staff's evaluation of his or her clinical competence. The Consulting Staff need not satisfy the geographic proximity requirements set forth in these Bylaws. Consulting Staff members must generate at least two (2) patient contacts at the Hospital during each twenty-four (24) month term of appointment; however, if the Consulting Staff member is a member of a group practice whose members are also members of the Medical Staff, then the patient contacts generated by a fellow-group practice member may, but are not required to, be considered by the Credentials Committee as satisfaction of this activity requirement.

5.6.2 Prerogatives of Consulting Staff. A Consulting Staff member may:

(a) Exercise such Clinical Privileges as are granted to him or her by the Governing Board, but may not admit patients to the Hospital;

(b) Attend, but not vote at, Medical Staff, department and section meetings; and

(c) Serve as a voting member of a Medical Staff committee, if requested to do so by the Chief of Staff; but may not serve as Medical Staff officer, a department or section chair or a Medical Staff committee chair;

5.6.3 Responsibilities of Consulting Staff. A Consulting Staff member must, in addition to meeting the basic obligations of Medical Staff appointment, fulfill the following duties:

(a) Provide consulting services to other Medical Staff members concerning their patients within a reasonable period of time.

(b) Offer other services within the scope of Practitioner's Clinical Privileges as requested by other Medical Staff members.

(c) If accepting a committee assignment, carry out such assignment in the same manner as required of an active staff member, including satisfying such meeting attendance requirements as are applicable.

5.7 Contract Staff.

5.7.1 Qualifications of Contract Staff. The Contract Staff shall consist of Practitioners who provide service on a regular and continuing basis in the Hospital under an exclusive contract with the Hospital. To be a member of the Contract Staff, a Practitioner must:

(a) Be engaged to provide services under an exclusive contract between the Hospital and Practitioner or the Hospital and the Practitioner's group contract;

(b) Meet all of the basic qualifications expressly set forth in these Bylaws; and

(c) Satisfy any other requirements set forth in the exclusive contract between the Hospital and Practitioner or the Hospital and the Practitioner's group.

5.7.2 Prerogatives of Contract Staff. A Contract Staff member may:

(a) Exercise Clinical Privileges granted to him or her by the Governing Board, subject to the exclusive contract between the Hospital and the Practitioner or the Hospital and the Practitioner's group.

(b) Serve as a member of Hospital or Medical Staff committees, as a Medical Staff officer, a department or section chair or a Medical Staff committee chair.

(c) Attend Medical Staff meetings; provided, however, that if more than one Contract Staff member from a group that includes Contract Staff members attends a Medical Staff meeting, only one Contract Staff member from each such group shall be eligible to cast a vote on behalf of the group at such Medical Staff meeting.

5.7.3 Limitation of Contract Staff Prerogatives. Notwithstanding any other provision of these Bylaws, a Contract Staff member's term of appointment and reappointment to the Medical Staff, scope of Clinical Privileges and procedural rights as a Medical Staff member shall be subject to the terms of the exclusive contract between the Hospital and the Contract Staff members or the Hospital and his or her group. If the exclusive contract is silent on the effect of termination of the exclusive contract on a Contract Staff member's Medical Staff membership and Clinical Privileges, and the Hospital determines in its sole discretion that the services should continue to be provided on an exclusive basis, the expiration or termination of the exclusive contract shall result in the termination of such Contract Staff member's Medical Staff membership and Clinical Privileges. Each contract staff member expressly waives any procedural due process rights under these Bylaws as a condition of being appointed to the Medical Staff category of Contract Staff.

5.7.4 Responsibilities of Contract Staff. A Contract Staff member must, in addition to meeting the basic obligations of Medical Staff appointment fulfill the following duties:

(a) Discharge the basic responsibilities specified in the Hospital's exclusive contract with such Practitioner or with the Practitioner's group.

(b) Cooperate with other Medical Staff members to facilitate the admitting process and the provision of care to patients as communicated to him or her by the patient's attending Physician, consistent with applicable standards of care.

(c) Fulfill the obligations of departments, if applicable and at a minimum, actively participate in the quality assurance activities and discharge such other staff functions as may be required from time to time.

(d) Provide call coverage as required in the Hospital's exclusive contract with such Practitioner or with the Practitioner's group.

5.8 Emeritus Staff. The Emeritus Staff shall consist of Practitioners who are no longer members of the Medical Staff, but who are appointed to this category in honor of their past service to the Medical Staff. To be appointed to the Emeritus Staff category, a Practitioner must be a Physician, Dentist, Podiatrist or Oral and Maxillofacial Surgeon who has retired from the Medical Staff and who has an outstanding record of service. Emeritus staff members need not reside in the Hospital's surrounding community. Emeritus Staff members shall not have any responsibilities or be required to satisfy the qualifications and requirements of Medical Staff membership. Emeritus Staff members may attend Medical Staff meetings; however, they may

not serve as a Medical Staff officer, a department or section chair or a Medical Staff committee chair or member. Emeritus Staff members also may not vote at any Medical Staff, department, section or Medical Staff committee meeting.

5.9 Community Affiliate Staff. The Community Affiliate Staff shall consist of Practitioners who have an active practice in the community served by the Hospital and who wish to be associated with the Hospital and refer patients to members of the Medical Staff but who do not wish to establish a clinical practice at the Hospital. The primary purpose of the Community Affiliate Staff is to promote professional collaboration and educational opportunities and to permit Practitioners with an active practice in the community to access services for their patients by direct referral of patients to members of the Medical Staff for admission, evaluation, and/or treatment.

5.9.1 Qualifications of Community Affiliate Staff. Community Affiliate Staff members shall be required to satisfy the basic qualifications expressly set forth in these Bylaws.

5.9.2 Prerogatives of Community Affiliate Staff. A Community Affiliate Staff member may:

(a) Not be eligible for Clinical Privileges and may not admit, treat, or discharge patients at the Hospital.

(b) Refer his or her patients to members of the Medical Staff, supply relevant information to Medical Staff members in the form of a patient history or physical (which shall become part of the patient's medical record when countersigned by the attending or admitting Medical Staff member), visit his or her patients while hospitalized, and have access to his or her patients' medical records for purposes of review, but may not write orders for, or make medical record entries on, hospitalized patients.

(c) Refer his or her patients to the Hospital's diagnostic facilities.

(d) Serve on Medical Staff committees and attend Medical Staff meetings and applicable department and section meetings, but may not: (i) serve as a Medical Staff officer, a department or section chair or a Medical Staff committee chair; (ii) vote at any Medical Staff, department or section meetings; and (iii) vote at any Medical Staff committee meeting, except at the meetings of Medical Staff committees to which he or she is appointed.

5.9.3 Limitation of Community Affiliate Staff Prerogatives. Each Community Affiliate Staff member expressly waives any procedural due process rights under these Bylaws as a condition of being appointed to the Medical Staff category of Community Affiliate Staff. Any instance of a Community Affiliate Staff member's noncompliance with these Bylaws, or any issues related to a Community Affiliate Staff member's delivery of quality patient care shall constitute a voluntary relinquishment of his or her Medical Staff membership without any procedural rights hereunder.

5.9.4 Responsibilities of Community Affiliate Staff. Community Affiliate Staff members must, in addition to meeting the basic obligations of Medical Staff

appointment, submit to the Medical Staff, upon request, various data and outpatient clinical indicators used to benchmark, measure and evaluate care quality.

ARTICLE SIX

DELINEATION OF CLINICAL PRIVILEGES

6.1 Exercise of Clinical Privileges.

6.1.1 In General. Except in the case of an emergency situation as set forth in Article 6.4 of these Bylaws, Disaster Privileges as provided in Article 6.5 below, or Temporary Clinical Privileges as provided in Article 6.6 below a Practitioner providing clinical services at the Hospital by virtue of Medical Staff membership Temporary Clinical Privileges may, in connection with such practice, exercise only those Clinical Privileges specifically granted to him or her by the Governing Board or as provided below for Temporary Clinical Privileges. Clinical Privileges shall be granted on the basis of training, experience and current clinical competence. There may be attached to any grant of Clinical Privileges to an individual Practitioner special requirements as a condition to the exercise of a particular privilege. Each Practitioner must pledge to provide, or arrange to provide, consistent with his or her delineated Clinical Privileges, for continuous medical care for his or her patients in the Hospital and to obtain appropriate consultation or refer the case to another qualified Practitioner when necessary or when required by the rules or other policies of the Medical Staff or the Hospital. Clinical Privileges are not a property right.

6.1.2 Requests for Clinical Privileges. Requests for Clinical Privileges will only be considered when made in writing and only when all the information specified in the Hospital's description of threshold requirements for Clinical Privileges is provided. In the event all requested information is not provided, the request for Clinical Privileges shall be considered incomplete. The Hospital, in its sole discretion, may deem an incomplete request for Clinical Privileges to be withdrawn and the Practitioner shall not be afforded procedural rights. Any request for Clinical Privileges for which there are no approved threshold requirements will be tabled for a period not to exceed 90 days. During this time period, the Credentials Committee shall seek to establish requirements for Clinical Privileges under which the request can be processed. Any new Clinical Privileges granted by the Governing Board shall be subject to the condition that the Practitioner agrees to satisfy any and all FPPE requirements of the Medical Staff. All threshold requirements for Clinical Privileges shall consist of baseline criteria specifying the minimum amount of education, training, experience and evidence of current competency required to perform the Clinical Privileges requested, and any other reasonable criteria related to quality of care, and shall be approved by the Medical Executive Committee and the Governing Board. Requests for Temporary Clinical Privileges shall be processed in accordance with the provisions set forth in Article 6.6 of these Bylaws.

Clinical Privileges shall be granted in accordance with the following:

(a) The Practitioner's education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and health status.

(b) The availability of qualified Physicians or other appropriate Practitioners to provide medical coverage for the Practitioner in case of the Practitioner's illness or unavailability.

(c) Adequate professional liability insurance coverage with respect to the Clinical Privileges requested.

(d) The Hospital's available resources and personnel.

(e) Any previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration, any voluntary or involuntary termination of Medical Staff appointment, or any voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at another hospital.

(f) Other relevant information, including a written report and findings by the chair of each of the clinical service areas in which such Clinical Privileges are sought.

The Practitioner has the burden of establishing the Practitioner's qualifications for competence to exercise the Clinical Privileges requested. The report of the chair of the clinical service area in which Clinical Privileges are sought shall be forwarded to the Credentials Committee and processed as part of the application.

6.2 Experimental, New, Untried or Unproven Procedures/Treatment Modalities/Instrumentation. Experimental drugs, procedures, or other therapies or tests may be administered or performed only after approval of the protocols involved by an Investigational Review Board and the Medical Executive Committee. Any experimental or other new, untried, or unproven procedure/treatment modality/instrumentation may be performed or used only after the regular credentialing process has been completed, and all necessary Clinical Privileges to perform or use said procedure/treatment modality/instrumentation has been granted to the individual Practitioner. For the purposes of this paragraph, a new, untried, or unproven procedure/treatment modality/instrumentation is one that is not generalizable from an established procedure/treatment modality/instrumentation in terms of involving the same or similar skills, the same or similar instrumentation and technique, the same or similar complications, the same or similar indications, or the same or similar expected physical outcome for the patient as the established procedure/treatment modality/instrumentation.

6.3 Processing Requests. All requests for Clinical Privileges, except those for Temporary Clinical Privileges, are processed according to the procedures outlined for the initial appointment and reappointment processes as applicable. Requests for Temporary Clinical Privileges are processed as outlined in Article 6.6 of these Bylaws.

6.4 Clinical Privileges In Emergency Situations. In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger, any Practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the Practitioner's license, but regardless of Medical Staff category or Clinical Privileges. A Practitioner providing services in an emergency situation that are outside his or her usual scope of Clinical Privileges is obligated

to summon all consultative assistance available as deemed necessary and to arrange for appropriate follow-up care. When the emergency situation no longer exists, such Practitioner must request the Temporary Clinical Privileges necessary to continue to treat the patient in accordance with the process outlined in Article 6.6 of these Bylaws, or the patient shall be assigned to a Practitioner that possesses the necessary Clinical Privileges to treat the patient.

6.5 Disaster Privileges.

6.5.1 Circumstances. In the case of a disaster that has resulted in the activation of the Hospital emergency management plan, the President, the Chief Medical Officer or his or her designee has the authority to grant disaster privileges. The President, the Chief Medical Officer, or his or her designee with the authority to grant disaster privileges, is not required to grant disaster privileges to any individual and shall make the decision to grant privileges on a case-by-case basis at his or her discretion, provided that the Practitioner seeking disaster privileges presents two of the following:

(a) A current picture Hospital identification card.

(b) A current license to practice and a valid picture identification issued by a state, federal, or regulatory agency.

(c) Identification indicating that the individual is a member of a Disaster Medical Assistance Team.

(d) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).

(e) Presentation by a current Hospital or Medical Staff member(s) with personal knowledge regarding the Practitioner's identity.

6.5.2 Management.

(a) Upon granting disaster privileges, the President, the Chief Medical Officer or his or her designee shall keep a written record of the information verified for each Practitioner granted disaster privileges and shall assign a Medical Staff member in the same specialty area to assist the Practitioner with disaster privileges as needed. The Medical Staff member providing assistance to the Practitioner with disaster privileges shall immediately report any concerns with the competence or care provided by the Practitioner to the President, the Chief Medical Officer or his or her designee who granted the disaster privileges.

(b) All Practitioners that have been granted disaster privileges shall wear a designated nametag that includes the following: (i) the words "Disaster Privileges"; (ii) the Practitioner's name; and (iii) the signature of the person granting the disaster privileges. This nametag shall be worn by the Practitioner at all times during which the Practitioner is exercising disaster privileges and shall be in clear view so that the Practitioner may be readily identified as a Practitioner granted disaster privileges.

6.5.3 Verification. It is a high priority for the Medical Staff to verify the credentials of any Practitioner granted disaster privileges and the process for such verification shall begin as soon as possible based on the circumstances surrounding the disaster or within 72 hours. Any Practitioner granted disaster privileges must request the Temporary Clinical Privileges necessary to continue to treat the patient in accordance with the process outlined in Article 6.6 of these Bylaws, or the patient shall be assigned to a Practitioner that possesses the necessary Clinical Privileges to treat the patient.

6.6 Temporary Clinical Privileges.

6.6.1 Eligibility. A Practitioner may be eligible for Temporary Clinical Privileges only if he or she:

(a) Is in Good Standing or has submitted a complete application for Medical Staff Appointment and the Credential Committee Chair confirms that there are no known issues with the application that would prevent the Credentials Committee from recommending appointment without any conditions;

(b) Submits a separate request for temporary privileges that includes the reason(s) why Clinical Privileges should be granted outside the normal credentialing process;

(c) Has been subject to a complete credentials verification process by the Medical Staff Office, including National Practitioner Data Bank inquiry; state license inquiry, and the Medical Staff Office has received a favorable recommendation that the Practitioner be granted the requested Temporary Clinical Privileges from the credentials committee chair or other responsible Medical Staff authority of all facilities the Practitioner has been principally affiliated with during the last five years;

(d) Has provided appropriate documentation that he or she satisfies the Hospital's professional liability insurance requirements and the Medical Staff Office has received a Certificate of Insurance; and

(e) Agrees in writing to abide by the Bylaws, Rules and Regulations and all other applicable Medical Staff and Hospital policies and procedures, and agrees that he or she shall continuously satisfy all Medical Staff member qualifications.

6.6.2 Grant of Temporary Clinical Privileges to Applicant for Initial Appointment to the Medical Staff. The President and/or the Chief Medical Officer may grant Temporary Clinical Privileges to a Practitioner who is applying for initial appointment to the Medical Staff only if the eligibility requirements set forth above in Article Six have been met, the Practitioner's initial application for appointment to the Medical Staff is complete, the Practitioner's request for initial appointment has received a positive recommendation without any conditions from the Credentials Committee, and the application is awaiting Medical Executive Committee review.

6.6.3 Grant of Temporary Clinical Privileges to Current Medical Staff Member to Fulfill an Important Patient Care, Treatment, and Service Need. The President and/or the Chief Medical Officer, along with the Chair of Credentials Committee, may

grant Temporary Clinical Privileges to a Practitioner for the care of a specific patient or patients only if the applicable eligibility requirements set forth above in Article Six have been met. When Temporary Clinical Privileges are granted under this Article Six, such privileges are effective for a maximum period of 120 days and are restricted to providing coverage or providing care to the specific patients for whom they are granted.

6.6.4 Grant of Temporary Clinical Privileges to a Preceptor. The President and/or the Chief Medical Officer along with the Chair of Credentials Committee may grant Temporary Clinical Privileges to a Practitioner who will be serving in the capacity as a preceptor only if the eligibility requirements set forth above in Article Six have been met.

6.6.5 Grant of Temporary Clinical Privileges to an Observer. The Chief Medical Officer may grant Temporary Clinical Privileges to a Practitioner for the sole purpose of observing within the facility or Surgical Services area. The Observer must be accompanied by a Practitioner, or designee, who is on staff and in good standing. The Medical Staff Office must be notified of such request at least one week prior to the event. Requirements for such activity will be as follows:

(a) Submission of an attestation by the sponsoring physician that the Observer is a licensed physician

(b) Signature of a Confidentiality agreement

(c) Submission of immunizations as outlined in Article Three

(d) Copy of Driver's License or Federally issued picture ID

(e) Agree to wear a KHS issued picture ID in the facility at all times

(f) Signed Release of Information

(g) Signed Attestation

6.7 Terms and Conditions of Temporary Privileges.

6.7.1 Grant of Temporary Clinical Privileges May Be Oral or Written. The granting of Temporary Clinical Privileges may be in writing or oral, provided that if granted verbally, the Medical Staff Office must document that the Practitioner has been granted Temporary Clinical Privileges in writing as soon as reasonably possible.

6.7.2 Special Requirements. Special requirements of supervision and reporting may be imposed on any individual granted Temporary Clinical Privileges

6.7.3 Termination of Temporary Clinical Privileges. The President, the Chief Medical Officer or, in his or her absence, his or her designee, may at any time at his or her own discretion or upon recommendation of the Chair of Credentials or Chief of Staff , terminate a Practitioner's Temporary Clinical Privileges, with or without cause, which

termination shall be effective immediately. Temporary Clinical Privileges may be granted for a maximum period up to 120 days, at which time the Temporary Clinical Privileges automatically terminate.

6.7.4 Rights of the Practitioner. A Practitioner is not entitled to the procedural rights afforded by Article Twenty of these Bylaws when his or her request for Temporary Clinical Privileges is refused in whole or in part or when all or any portion of his or her Temporary Clinical Privileges are terminated, not reviewed, restricted, suspended, or limited in any way.

ARTICLE SEVEN

REAPPOINTMENT PROCEDURES

7.1 Reappointment Application. Each current appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form. Each applicant for reappointment must satisfy all the qualifications for Medical Staff membership and Clinical Privileges set forth in Article Four of these Bylaws, and any other requirements set forth in these Bylaws. No Practitioner shall be automatically entitled to reappointment at the time of reappraisal merely because he or she had, or presently has, Medical Staff membership or Clinical Privileges or holds a Medical Staff officer position or other administrative position with Hospital. Reappointment, if granted, shall be for a period of not more than 24 months.

7.2 Contents of Application. The reappointment application shall include complete information and copies of all documents necessary to bring Practitioner's file current on all requested items, including, but not limited to the information described in Article Four of these Bylaws. In addition, the reappointment application shall include the following:

7.2.1 Completion of a Supplemental Reapplication Form; and

7.2.2 A signed reappointment application accepting the same conditions as stated in Article Four of these Bylaws.

7.3 Request for Change in Clinical Privileges or Category. The reappointment application may include the following:

7.3.1 A specific request for additions to or deletions from the Clinical Privileges presently held, with any basis for changes; and

7.3.2 A request for a change in Medical Staff category.

7.4 Time Periods for Submission of Information. At least 90 days prior to the date of expiration of a Medical Staff member's appointment, the Medical Staff Office shall notify Practitioner of the date of expiration and send him or her instructions on how to complete the reappointment application. At least 45 days prior to the expiration date, the Practitioner shall complete and forward to the Medical Staff Office the state-mandated reappointment application and other required documents or be subject to late fees.

Failure to provide the full complete reappointment application prior to or within the 45-day period following the initial notification shall be deemed a voluntary withdrawal of the reappointment application and, as a result, the Practitioner's of Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights. A Practitioner whose appointment and Clinical Privileges are relinquished under this provision must reapply as an initial applicant to the Medical Staff.

7.5 Burden of Providing Information. The Practitioner shall have the burden of providing information deemed adequate for a proper evaluation of competence, character, ethics and other qualifications and of resolving any doubts about such qualifications. In addition, the Practitioner shall have the burden of providing evidence that all the statements made and information given are true and correct. The Practitioner's failure to provide true and correct information shall be deemed a voluntary withdrawal of the reappointment application and, as a result, the Practitioner's of Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights. Should information provided in the initial application change during the course of an appointment period, the Practitioner has the burden and duty under Article Four of these Bylaws to immediately provide information about such change.

7.6 Statements, Releases, Authorizations and Consents. Each Practitioner who seeks reappointment to the Medical Staff expressly accepts and agrees to the statements, releases, authorizations, consents and conditions set forth in Article Four of these Bylaws.

7.7 Credentials Committee Evaluation and Action. Members of the Credentials Committee shall review the application, the supporting documentation and all other relevant information available to it. A Credentials Committee member shall attempt to refrain from reviewing an application of a Practitioner within their practice group and will refer the file to another member of the Credentials Committee. The Credentials Committee may, in its sole discretion, conduct an interview with the Practitioner or designate one or two of its members to do so. If the Committee requires further information, it may defer transmitting its report not more than 30 days, and it must notify the Practitioner and Chief of Staff in writing of the deferral and the grounds. If the Practitioner is to provide additional information or a specific release/authorization to allow Hospital Representatives to obtain additional information, the notice to him or her must be a written notice requesting such information of a release/authorization to obtain such information. The notice shall include a request for the specific data/explanation requested and the time frame for such response. Failure to respond in a satisfactory manner by that date shall be deemed a voluntary withdrawal of the reappointment application and, as a result, the Practitioner's Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights.

The Credentials Committee shall prepare a written report with recommendations for, and any special limitations on, reappointment or nonreappointment, Medical Staff category, and Clinical Privileges. The Credentials Committee's report is transmitted to the Medical Executive Committee.

7.8 Unwarranted Delay. If unwarranted delay occurs at any step in the process, and such delay is attributable to a Medical Staff committee or any Hospital authority, the next higher

authority may immediately proceed to consider the reappointment application and all the supporting information or may be directed by the Chief of Staff on behalf of the Medical Executive Committee, or by the President and/or the Chief Medical Officer on behalf of the Governing Board, to so proceed. If the delay is attributable to the Practitioner's failure to provide information required under any provision of this Article Seven, as determined by the Medical Executive Committee, his or her reappointment application shall be deemed voluntarily withdrawn and, as a result, his or her Medical Staff appointment and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights.

7.9 Medical Executive Committee Review. The Medical Executive Committee shall review the Credentials Committee's recommendation and any pertinent information it deems appropriate. After review, the Medical Executive Committee shall take one of the following actions: deferral, favorable recommendation, or unfavorable recommendation as described in Article Four of these Bylaws.

7.10 Final Processing and Governing Board Action. Final processing of reappointments follows the procedure set forth in Article Four of these Bylaws. For purposes of reappointment, the term "application" as used in said sections shall mean "reappointment." Failure by the Practitioner to provide information to complete an application or to appear when requested and given proper notice, shall be deemed a voluntary withdrawal of the reappointment application and, as a result, his or her Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights.

ARTICLE EIGHT

MODIFICATION OF APPOINTMENT STATUS OR CLINICAL PRIVILEGES

8.1 Options for Modification of Appointment Status or Clinical Privileges.

8.1.1 Practitioner Request for Modification of Appointment Status or Clinical Privileges. A Practitioner may, either in connection with reappointment or at any other time, request modification of his or her Medical Staff category or Clinical Privileges by submitting a written request to the Medical Staff office. A change in status or Clinical Privileges is processed according to the procedures outlined in Articles Four and Seven of these Bylaws, as appropriate to the context, and must contain all pertinent information supportive of the request.

8.1.2 Requests for Leave of Absence. Members of the Medical Staff may submit a written request for a leave of absence to the Credentials Committee. Such request shall state the beginning and ending dates of the leave of absence up to one year. The request is forwarded to the Medical Executive Committee and on to the Governing Board for final approval. If the Leave of Absence is granted, the following apply:

(a) During a leave of absence, Clinical Privileges and membership responsibilities and prerogatives are voluntarily suspended.

(b) One extension of a leave of absence may be granted, although no leave of absence period shall exceed a total of 24 months.

(c) In the event a Practitioner is scheduled for reappointment pursuant to Article Seven of these Bylaws, during a leave of absence, such reappointment process must be completed in accordance with these Bylaws. If the Practitioner does not complete the reappointment process, the Practitioner's Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights and may be reinstated only if he or she submits an application pursuant to Article Four of these Bylaws.

(d) The Practitioner must submit a request for reinstatement according to Article Eight of these Bylaws. If there is no request for reinstatement and the leave of absence exceeds 24 months, the Practitioner's Medical Staff membership and Clinical Privileges shall expire at the end of his or her then-current term of appointment without procedural rights.

If the leave of absence is denied, that information will be communicated to the Medical Staff member.

8.2 Reinstatement Following a Modification or Leave of Absence.

8.2.1 General. Reinstatement allows Medical Staff personnel who have been granted a leave of absence to return to their previous position. This process in no way replaces a Medical Staff members need to apply for reappointment once a Medical Staff member's term has ended. If the Medical Staff member's Clinical Privileges remain suspended past the end of the Medical Staff member's term, the Practitioner will be required to initiate reinstatement and reappointment proceedings.

8.2.2 Request for Reinstatement.

(a) Prior to the date on which the Practitioner desires to be reinstated, the Practitioner will provide the Credentials Committee with a letter requesting reinstatement that will be reviewed at the next scheduled Credentials Committee meeting. This letter will contain:

(i) A specific request for reinstatement.

(ii) The date on which the reinstatement is desired.

(iii) The nature of the reinstatement desired.

(iv) The reason for the leave of absence, temporary restriction, or withdrawal of Clinical Privileges.

(v) A written report or other documentation of the professional activities, if any, engaged in during his or her absence.

(vi) A letter from the physician director of any rehabilitation program attended during the suspension of his or her Clinical Privileges, or the primary physician treating the Practitioner for any condition relevant to the Practitioner's reinstatement, as applicable.

(vii) Consent/authorization to allow Hospital Representatives to contact the parties and obtain additional needed information.

(viii) Any additional information as required by the Hospital or President and/or the Chief Medical Officer of the Hospital as a condition to the Medical Staff member's reinstatement.

(b) If the Practitioner provides an incomplete request for reinstatement, the Chair of the Credentials Committee will send written notice to the Practitioner that his or her request for reinstatement is incomplete. This notice will advise the Medical Staff member:

(i) Of the nature of the information and/or documents missing from his or her request for reinstatement; and

(ii) That the Practitioner has until the next regularly scheduled Credentials Committee meeting in which to submit the missing information and/or documents.

(c) If the Practitioner does not complete the reinstatement request in accordance with section 8.2.2 it shall be deemed to be a voluntary withdrawal of the reinstatement request, without procedural rights; however, if the withdrawal of a reinstatement request occurs after the expiration of the maximum 24-month period for a leave of absence, the withdrawal of the reinstatement request shall be deemed an automatic voluntary relinquishment of Medical Staff membership and Clinical Privileges under Article Twenty of these Bylaws irrespective of the time remaining for Practitioner's then-current term of appointment.

8.2.3 Verification of Information By Hospital. The Medical Staff Office will verify the information received from the Medical Staff member. The Practitioner will be notified of any information inadequacies or verification problems by written notice from the Medical Staff Office, which will include the nature of the needed information and the time frame for response. Failure to respond satisfactorily within the time period will be deemed a voluntary withdrawal of the request for reinstatement. Only when all of the information required is received will the application be sent to the Credentials Committee.

8.2.4 Review and Evaluation of Request and Information. The Credentials Committee shall review the reinstatement request, the supporting documentation, and any other relevant information available to it. The Credentials Committee may, in its sole discretion, conduct an interview with the Practitioner or designate two or more of its members to do so. If the Credentials Committee requires further information, it may defer transmitting its report not more than 30 days, and it must notify the Practitioner and the Chief of Staff in writing of the deferral and the grounds. If the Practitioner is to provide the additional information or a specific release/authorization to allow Hospital Representatives to obtain information, the notice to him or her must so state, must be a written notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application for reinstatement

and an automatic voluntary relinquishment of Medical Staff membership and Clinical Privileges under Article Twenty-one of these Bylaws.

8.2.5 Conditions of Reinstatement. The Credentials Committee may recommend to fully reinstate the Practitioner or to place conditions on such reinstatement. Reinstatement may be conditional on any one or more of the following:

(a) Participation in ongoing treatment by the Medical Staff member.

(b) Submission by the Practitioner of letters from at least one member of the Medical Staff indicating the willingness of these members to promptly assume responsibility for the care of the Medical Staff member's patients in the event that the Practitioner becomes unable to care for such patients.

(c) Authorization by the Practitioner of persons deemed appropriate by the Chief of Staff, the Chief Medical Officer and President, to submit periodic reports to the Hospital for a period of time deemed appropriate by the Chief of Staff, the Chief Medical Officer and the President. Such reports shall indicate whether the ability of the Practitioner appears impaired and whether the Practitioner is continuing treatment or therapy, where applicable.

(d) Monitoring of the Medical Staff member's exercise of admitting and Clinical Privileges, in accordance with the FPPE policies and procedures of the Medical Staff, which may include:

(i) Periodic chart review;

(ii) Patient care supervision;

(iii) Blood/urine screening;

(iv) Proctoring of procedures;

(v) Additional education or training at Practitioner's sole expense; and/or

(vi) Any other measures deemed necessary.

(e) Agreement by the Practitioner to submit to periodic blood/alcohol screening.

If conditions are placed on the Medical Staff member's reinstatement and the Practitioner is ultimately reinstated, the failure to comply with any conditions of the reinstatement shall be deemed an automatic voluntary relinquishment of Medical Staff membership and Clinical Privileges under Article Twenty-one of these Bylaws regardless of the time remaining for Practitioners then-current term of appointment. In such case the Practitioner will be required to submit a new application for appointment, as an initial applicant to the Medical staff.

8.2.6 Action After Evaluation. After reviewing the provided information, the Credentials Committee shall make a recommendation concerning reinstatement, as well as any limitations on the reinstated Medical Staff member's Clinical Privileges to the Medical Executive Committee.

The Credentials Committee shall review the reinstatement request, the supporting documentation, and the reports from the Chief of Staff, the Chief Medical Officer and the President, and any other relevant information available to it. The Credentials Committee may conduct an interview with the Practitioner or designate two or more of its members to do so. If the Credentials Committee requires further information, it may defer transmitting its report not more than 30 days, and it must notify the Practitioner and the Chief of Staff in writing of the deferral and grounds. If the Practitioner is to provide the additional information or a specific release/authorization to allow Hospital Representatives to obtain information, the notice to him or her must so state, must be a written notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application for reinstatement, and in the case of a reappointment application, an automatic voluntary relinquishment under Article Twenty-one of these Bylaws.

8.2.7 Voluntary Withdrawal of Reinstatement Request. At any time during the reinstatement process, except as otherwise specifically provided in these procedures, the Practitioner may voluntarily withdraw his or her request for reinstatement by providing written notice to the Chief of Staff, the Chief Medical Officer and the President. In such event, Practitioner will not be entitled to procedural rights.

8.3 Medical Executive Committee Action. The Medical Executive Committee shall review the Credentials Committee recommendation and any pertinent information it deems appropriate. After review, the Medical Executive Committee shall take one of the following actions: deferral, favorable recommendation, or unfavorable recommendation as described in Article Four of these Bylaws.

8.4 Final Processing And Governing Board Action. Final processing of reinstatements follows the procedure set forth in Article Four of these Bylaws. For purposes of reinstatement, the term "application" as used in said sections shall mean "reinstatement."

ARTICLE NINE

MEDICAL STAFF OFFICERS

9.1 Medical Staff Officers Generally.

9.1.1 Identification. The Medical Staff officers shall be:

(a) Chief of Staff;

(b) Vice Chief of Staff; and

(c) Immediate Past Chief of Staff.

9.1.2 Qualifications. Each Medical Staff officer must satisfy the following qualifications:

(a) Member of Active or Contract Staff in Good Standing. Be a member of the Active or Contract Staff in Good Standing at the time of nomination and continue to remain in Good Standing throughout the term of office and have served as a member of the Active or Contract Staff for at least four (4) years prior to nomination; however, if an officer fails to maintain Good Standing during the term of office, then the Medical Executive Committee shall review the matter and may waive this qualification.

(b) Faithful Discharge of Duties. Agree to willingly and faithfully discharge the duties and exercise the authority of the office held by working in cooperation with the other Medical Staff officers, department chairs, the Medical Staff and its committees and the KHS Chief Executive Officer, the Chief Medical Officer, or the President and the Governing Board.

(c) Sufficient Clinical Activity at Hospital. Have a level of clinical activity at the Hospital that is substantial enough with respect to Practitioner's entire practice to allow the Practitioner to effectively fulfill his or her role as a Medical Staff officer.

(d) Demonstrated Interest in Quality Care. Have demonstrated interest in maintaining quality medical care at the Hospital.

(e) No Adverse Professional Review Actions Pending. Have no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges at any KHS facility or any other facility at which Practitioner is a medical staff member.

(f) Participation in Medical Staff Affairs. Have constructively participated in Medical Staff affairs, including Professional Review Activities and participation on Medical Staff committees and served on at least two (2) other Medical Staff or Hospital committees or served on a committee for two (2) terms prior to nomination.

(g) Education. Participate in conferences, seminars and other educational programs as recommended by the Hospital.

(h) Experience. Possess and have demonstrated executive and administrative ability through experience, prior constructive participation in Medical Staff affairs, and recognition as possessing a high level of clinical competence.

(i) Commitment. Demonstrate a high degree of interest in and support of the Medical Staff and Hospital by his or her Medical Staff tenure and level of clinical activity at the Hospital.

(j) Knowledge of Position. Be knowledgeable concerning the duties of the office.

(k) Communication Skills. Possess satisfactory written and oral communication skills.

(l) Demonstrated Interpersonal Skills. Possess and have demonstrated the ability for harmonious interpersonal relationships.

(m) Manage Conflicts and Comply with Conflicts Policies. Comply with and agree to be subject to any Conflict of Interest policies adopted by the Medical Executive Committee or set forth in these Bylaws.

(n) Citizenship. Have the ability to appropriately represent the Medical Staff to the community and be regarded as a good citizen of the community.

(o) Eligibility. Not be an employee of another Hospital or Hospital Affiliate.

9.1.3 Holding of Offices Simultaneously. A Practitioner may not simultaneously hold: (a) two or more Medical Staff officer positions; (b) a Medical Staff officer position and the position of department chair; or (c) either a Medical Staff officer position or the position of department chair at both the Hospital and another hospital. These prohibitions shall apply unless waived by the Medical Executive Committee and the Governing Board.

9.2 Term of Office. Officers shall be elected for a term of two (2) years. Thereafter, such Practitioner shall be eligible for reelection after one (1) year has elapsed since he or she held office. Unless an exception is granted by the Medical Executive Committee, a Practitioner holding the office of Chief of Staff, Vice Chief of Staff or Immediate Past Chief of Staff shall be eligible again for nomination and election after the earlier of completing his or her term as Immediate Past Chief of Staff or the expiration of one (1) year since he or she last held office. Officers assume office on the first day of the Medical Staff year following their election, except that an officer elected or appointed to fill a vacancy assumes office immediately upon election or appointment. Each officer serves until the end of his or her term and until a successor is elected, unless he or she resigns sooner or is removed from office.

9.3 Attainment of Office; Election Process.

9.3.1 Attainment of Office.

(a) Chief of Staff. The Chief of Staff attains office by automatic succession from the office of Vice Chief of Staff.

(b) Vice Chief of Staff. The Vice Chief of Staff shall be elected in accordance with the process identified in Article 9.3.2 of these Bylaws.

(c) Immediate Past Chief of Staff. The Immediate Past Chief of Staff attains office by automatic succession from the office of Chief of Staff.

9.3.2 Election Process.

(a) Nomination Process. At least two (2) months prior to the annual Medical Staff meeting at which an election for Medical Staff officers is to occur, the nominating

committee shall convene for the purpose of nominating one (1) qualified candidate for the office of Vice Chief of Staff. This list will be forwarded to the Medical Executive Committee for receipt and publication to the Medical Staff a minimum of five (5) days prior to election. If, before the election, any nominated Practitioner requests to be removed as a candidate, is disqualified or is otherwise unable to accept nomination, then the nominating committee may submit a qualified, substitute nominee(s) at the annual Medical Staff meeting.

(b) Nominations at the Annual Medical Staff Meeting. At the annual Medical Staff meeting, additional nominations of qualified candidates for the office of Vice Chief of Staff may be made from the floor. Nominations of qualified Practitioners from the floor offered and seconded by active staff members in Good Standing will be accepted. All such nominations must be presented with evidence of the candidate's qualifications and of his or her willingness to be nominated.

(c) Method of Election. Officers shall be elected by the majority vote of those Medical Staff members eligible to vote who are present and voting at the annual Medical Staff meeting. If no candidate for a given office receives a majority vote on the first ballot, a runoff election is held immediately between the two candidates receiving the highest number of votes. The results of the election shall be presented to the Governing Board.

9.4 Vacancies.

9.4.1 Office of Chief of Staff. A vacancy in the office of Chief of Staff is filled by automatic succession of the Vice Chief of Staff who serves the remainder of the unexpired term.

9.4.2 Office of Vice Chief of Staff. A vacancy in the office of Vice Chief of Staff is filled by appointment of a qualified Practitioner by the Medical Executive Committee. The replacement officer serves pending the outcome of a special election to be conducted as expeditiously as possible and generally in the same manner as provided in Article 9.3.2; provided, however, that the Medical Executive Committee may determine not to call a special election if a regular election for the office is to be held within 180 days, in which case the acting officer serves only until the election results are final and the Practitioner then elected assumes office immediately.

9.4.3 Office of Past Chief of Staff. A vacancy in the Past Chief of Staff shall remain vacant.

9.5 Resignation and Removal from Office.

9.5.1 Resignation. Any Medical Staff officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any other time specified in the resignation.

9.5.2 Removal from Office.

(a) Removal by the Governing Board. The Governing Board may remove an officer at any time during his or her term of office if, in the sole discretion of the Governing Board, it determines that the officer has failed to meet the qualifications for office set forth in Article 9.1.2 of these Bylaws, unless the removal is due to failure to maintain Good Standing and the Medical Executive Committee grants a waiver of such qualification under Article 9.1.2.(a). Such removal shall be effective only if written notice of such proposed action is given to such officer at least ten (10) days prior to the date of the meeting at which the removal decision is to be made and the officer is afforded the opportunity to speak at the Governing Board meeting prior to the taking of any vote on such removal.

(b) Removal by Medical Executive Committee. The Medical Executive Committee may remove any Medical Staff officer by two-thirds (2/3) majority vote of the Medical Executive Committee at a meeting at which quorum is present for: (i) failure to meet any of the qualifications set forth herein for such office; (ii) conduct detrimental to the interests of the Hospital or the Medical Staff; or (iii) if the officer is suffering from a physical or mental infirmity that renders the Medical Staff member incapable of fulfilling the duties of that office. Such removal shall be effective only if written notice of such proposed action is given to such officer at least ten (10) days prior to the date of the meeting at which the removal decision is to be made and the officer is afforded the opportunity to speak at the Medical Executive Committee meeting prior to the taking of any vote on such removal.

(c) Failure to Continuously Satisfy Qualification. A Medical Staff Officer's failure to satisfy the qualifications for an officer shall be treated as a resignation, and any vacancy created filled in accordance with Article 9.3.2 of these Bylaws, unless the removal is due to failure to maintain Good Standing and the Medical Executive Committee grants a waiver of such qualification under Article 9.1.2.(a).

9.6 Responsibilities and Authority of Officers.

9.6.1 Chief of Staff. As the highest ranking Medical Staff officer, the Chief of Staff has the following responsibilities and authority:

(a) Preside at, and be responsible for, the agenda of all general and special meetings of the Medical Staff and of the Medical Executive Committee.

(b) Assist the Chief Medical Officer in coordinating activities and the delivery of services with Medical Staff departments.

(c) Appoint members and assign chairs to all Medical Staff committees of the Medical Staff, except as otherwise provided in these Bylaws.

(d) To the extent required by the Hospital's corporate bylaws, serve as a nonvoting, *ex officio* member of the Governing Board.

(e) Represent the views, policies, needs and grievances of the Medical Staff to the Chief Executive Officer, the Chief Medical Officer, the President and the Governing Board.

(f) Act as a spokesman for the Medical Staff and its external professional and public relations.

(g) Serve as chair of the Medical Executive Committee and as a nonvoting, *ex officio* member of all other standing Medical Staff committees, unless otherwise provided in the statement of the committee's composition.

(h) Be responsible for the enforcement of these Bylaws, the Rules and Regulations, the Allied Health Provider Credentialing Policy and any other policy of the Medical Staff or the Hospital, for implementation of sanctions where indicated and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner.

9.6.2 Vice Chief of Staff. As the second-ranking elected Medical Staff member, the Vice Chief of Staff has the following responsibilities and authority:

(a) Assume all of the duties and responsibilities and exercise all of the authority of the Chief of Staff when the latter is temporarily or permanently unable to fulfill the same.

(b) Serve as a voting member of the Medical Executive Committee and the Bylaws Committee, and serve as the chair of the Bylaws Committee during the second year of his or her term.

(c) Perform such additional duties and exercise such authority as may be assigned or granted by the Chief of Staff, the Medical Executive Committee, the Governing Board or in these Bylaws or other Medical Staff or Hospital policies.

9.6.3 Immediate Past Chief of Staff. The Immediate Past Chief of Staff has the following responsibilities and authority:

(a) Serve as a voting member of the nominating committee.

(b) Perform such duties as may be assigned by the Chief of Staff, the Medical Executive Committee or in these Bylaws or other Medical Staff or Hospital policies.

ARTICLE TEN

DEPARTMENTS

10.1 Clinical Departments Generally.

10.1.1 List of Departments. The Medical Staff shall be organized into the clinical departments listed below. Each department may include such clinical sections as are created in accordance with these Bylaws:

(a) Anesthesia;

(b) Emergency Medicine;

(c) Family Medicine;

(d) Medicine;

(e) Obstetrics and Gynecology;

(f) Pathology;

(g) Pediatrics;

(h) Radiology; and

(i) Surgery.

10.1.2 Process for Establishing Departments. The Medical Executive Committee will periodically restudy this structure and recommend to the Governing Board what action is desirable in creating new departments or eliminating or combining departments for better organizational efficiency and improved patient care. Action taken by the Governing Board pursuant to this Article 10.1.2 shall be effective on such date as determined by the Governing Board and shall require formal amendment of these Bylaws. The criteria set forth in Article 10.1.3 below and such other criteria as may be deemed appropriate shall be used by the Medical Executive Committee and the Governing Board in making recommendations and taking action under this Article 10.1.2 with respect to department designations. The Medical Executive Committee or Governing Board may make exceptions to those criteria as deemed appropriate in the best interests of fulfilling major purposes, objectives or commitments of the institution. Any department created or existing as such an exception must satisfy the functions of departments required under Article 10.1.4 below.

10.1.3 Department Criteria. The following criteria shall apply in making department designations:

(a) The area of practice represents a major, general, distinct field of medical practice at the Hospital;

(b) The level of clinical activity at the Hospital is substantial enough to warrant imposing the responsibility to accomplish the functions assigned to departments; and

(c) The Practitioners to be assigned to the department agree to and, in fact, carry out the meeting and other activities required of departments at the Hospital.

10.2 Functions of Departments.

10.2.1 Generally. Departments fulfill certain clinical, administrative, quality review/professional liability prevention/utilization management and collegial and education functions as set forth in this Article. Through election to Medical Staff offices

and participation by departments' representatives on committees, the Medical Staff members affiliated with each department performs these same functions on a multidisciplinary, Medical Staff-wide, and Hospital-wide basis. Each department must meet as required under Section 10.3 for the purpose of receiving reports on the findings of review and evaluation of the quality and efficiency of care provided to patients served by the department and for such other purposes as may be necessary to carry out the functions required in this Article.

10.2.2 Clinical Functions. Each department shall:

(a) Establish, implement and monitor Medical Staff members' adherence to clinical standards, policies, procedures and practices relevant to the Clinical Privileges granted by the Governing Board;

(b) Provide an interspecialty and interdepartmental forum for matters of clinical concern and for resolving clinical issues arising out of the interface between its members' activities and the activities of other patient care and administrative services;

(c) Develop consistency in the patient care data, standards, policies, procedures and practices within the department and across any of the its constituent subspecialties; and

(d) Develop criteria for use in making credentials recommendations on initial appointments, reappointments, granting of Clinical Privileges, and other credentials matters, and make such recommendations on these matters as required by the Bylaws and approved by the Medical Executive Committee.

10.2.3 Administrative Functions. Each department shall:

(a) Provide a forum for its members to contribute their professional views and insights to the formulation of the department, Medical Staff and Hospital policies and plans;

(b) Communicate, through its chair, formulated policies and plans for implementation by department members;

(c) Coordinate, through its chair, the professional services of its members with those of other departments and with Hospital and Medical Staff support services; and

(d) Make recommendations, through its chair, to the Medical Executive Committee, the Chief Executive Officer, the Chief Medical Officer and other components, as appropriate, concerning the short-term and long-term allocation and acquisition of resources to and provision of services by Hospital and the departments.

10.2.4 Quality Review/Professional Liability Prevention/Utilization Management Functions. Each department shall:

(a) Analyze quality review, professional liability prevention and utilization data and findings pertinent to the department, and make recommendations or take action as appropriate;

(b) Conduct mortality and morbidity reviews, perform specified monitoring and evaluation activities, and otherwise participate as required in the quality review, professional liability prevention and utilization management program; and

(c) Report all findings of monitoring and evaluation activities performed under this Article to the Medical Staff Executive Committee and any other relevant Medical Staff committees.

10.2.5 Collegial and Education Functions. Each department that has no designated subspecialty shall serve as the most immediate peer group for:

(a) Providing clinical support among and between peers;

(b) Teaching, research, continuing education and sharing new knowledge relevant to the practice of department members;

(c) Planning for and supporting the provision and coordination of patient education activities; and

(d) Providing consultative advice to other Medical Staff members.

10.3 Department Chairs.

10.3.1 Qualifications. Each department chair shall be a member of the active staff or the contract staff who possesses and, for his or her term of office, maintains at all times, the same qualifications as those required of Medical Staff officers set forth in Article 9.1.2 of these Bylaws.

10.3.2 Term of Office and Election.

(a) Term of Office. Except as otherwise provided in this Article, Department chairs shall serve a term of two (2) years, beginning on the first day of the Medical Staff year. A department chair may be reelected for one additional two-year term. Thereafter, such Practitioner shall be eligible for reelection only after one (1) year has elapsed since he or she held office. Chairs of departments that are comprised of less than three (3) Medical Staff members or Contract Staff only shall not be subject to term limits.

(b) Election. Candidates for all department chair positions shall be selected by department members and voting shall be completed by April 30.

10.3.3 Resignation. A department chair may resign at any time by giving written notice to the Medical Executive Committee. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified in the resignation.

10.3.4 Removal.

(a) Removal by Governing Board. If, at any time during his or her term of office, a department chair fails to satisfy any of the qualifications set forth in Article 9.1.2 of these Bylaws, he or she may be removed by the Governing Board; provided, however, that such removal shall occur only in the absence of action by the Medical Executive Committee or the department members.

(b) Removal by Medical Executive Committee. The Medical Executive Committee may remove any department chair by two-thirds (2/3) majority vote of the Medical Executive Committee at a meeting at which quorum is present if it determines such department chair has: (i) failed to meet any of the qualifications set forth herein for such office; (ii) engaged in conduct detrimental to the interests of the Hospital; (iii) or suffers from a physical or mental infirmity that renders such department chair incapable of fulfilling the duties of that office. Such removal shall be effective only if written notice of such proposed action is given to such department chair at least ten (10) days prior to the date of the meeting at which the removal decision is made and the department chair is afforded the opportunity to speak at the Medical Executive Committee meeting prior to the taking of any vote on such removal.

(c) Removal by Department Members. Removal of a department chair may be initiated only by a two-thirds (2/3) majority vote by secret ballot of the department members who are eligible to vote and present at a special meeting called for that purpose. A quorum for this purpose will be two-thirds (2/3) of the department members. The department chair who is the subject of the removal action shall be given fifteen (15) days' prior written notice of the meeting at which the vote on removal is to be taken and shall be afforded the opportunity to speak in his or her own behalf before the department prior to the taking of any vote on his or her removal.

10.3.5 Vacancies. A vacancy in the office of department chair is filled by the immediate past chair. The immediate past chair serves as department chair pending the outcome of a special election to be conducted as expeditiously as possible. The newly elected chair will serve the remainder of the term.

10.3.6 Responsibilities of Department Chairs. A department chair has the responsibility and authority to carry out the functions delegated to him or her and to the department by the Governing Board, by the Medical Executive Committee in these Bylaws, and, where applicable, by contract or job description. More specifically, each department chair shall:

(a) Be responsible for all professional, clinical and administrative activities within his or her department.

(b) Participate in planning with respect to the department's personnel, equipment, facilities, services and budget to ensure that operations are effective and efficient and that adequate space, equipment, and other necessary resources are available to the department personnel.

(c) Serve on the Medical Executive Committee, give guidance to the Medical Executive Committee on the medical policies of the Hospital related to his or her department and make specific recommendations and suggestions regarding the department to the Medical Executive Committee, Hospital management and the Governing Board.

(d) Assist in developing, implementing and supervising relevant Medical Staff components of the quality review, professional liability prevention and utilization management program as required in the Medical Staff Bylaws in cooperation with the Chief of Staff, the Medical Executive Committee, the Patient Services committee, other relevant Staff committees and the Governing Board.

(e) Maintain continuing review of patient care and the professional performance of Practitioners and allied health professionals with Clinical Privileges or specified services in the department to ensure that such professionals are held accountable for their responsibilities.

(f) Engage in short-term and long-term planning for the department.

(g) Ensure appropriate processes for the coordination of care, treatment and services among other departments.

(h) Establish, when appropriate, sections within the department and appoint a section chair, subject to the approval of the Medical Executive Committee and the Governing Board.

(i) Present written reports, as appropriate, requested or required, to the Medical Executive Committee concerning patterns or situations affecting patient care, and to the Patient Services Committee and other staff or Hospital committees when appropriate or required. In performing the duties set forth herein, the chair may, in his or her absolute discretion, delegate investigative tasks to others, who shall report to appropriate committees.

(j) Review data/information forwarded from the various Medical Staff committees charged with quality review, professional liability prevention or utilization management activities, respond to requests from and recommendations by said committees and make recommendations or take action as appropriate.

(k) Assist in developing and implementing policies and procedures that guide and support patient care, treatment and services.

(l) Effectively communicate and implement within the department actions taken by the Medical Executive Committee, the Governing Board and other relevant authorities.

(m) Prepare and transmit to the appropriate authorities, as required by the Medical Staff Bylaws and other applicable credentialing protocols, recommendations concerning appointment, reappointment, delineation of Clinical Privileges or specified services and corrective action with respect to Practitioners and allied health professionals holding membership or exercising Privileges in the department.

(n) Enforce the Hospital's corporate bylaws and the Medical Staff Bylaws, rules, policies and procedures within the department; including, initiating corrective action and investigation of clinical performance and ordering consultations to be provided or sought when necessary.

(o) Unless otherwise provided in the Medical Staff Bylaws, assign individual department members and appoint department committees as necessary to perform the functions of the department and designate a chair of each committee created.

(p) Preside over and prepare the agenda for all meetings of the department with assistance from the Medical Staff Office.

(q) When the department chair is not available, the immediate past chair will assume the duties of the chair as needed, including attendance at Medical Executive Committee meetings with a vote.

(r) Recommend to the Medical Staff the qualifications and criteria for Clinical Privileges that are relevant to the care provided in the department.

(s) Assess and recommend to the relevant Hospital authority off-site sources for needed patient care services not provided by the department or KHS.

10.3.7 Reporting Obligations of Department Chairs. Each department chair shall report:

(a) To regularly scheduled or special meetings of the Medical Executive Committee and the department on the activities of the department and its constituent subspecialties and its sections, if any, and, as requested, to special meetings of the Medical Executive Committee and of the department and to regular or special meetings of the Medical Staff on these same matters.

(b) Whenever necessary or requested, to the Chief of Staff on matters involving coordination and monitoring of clinical services to maintain quality or to assure patient safety.

(c) To the Chief of Staff and the Medical Executive Committee on action taken in response to a suggestion, recommendation or finding from one of the Medical Staff's committees.

(d) To the President and/or the Chief Medical Officer, on issues relating to the department chair's administrative duties, if any, for supervision of Hospital personnel, proper functioning of equipment and efficient scheduling.

(e) To the Medical Executive Committee, the President, the Chief Medical Officer, on issues relating to the allocation and acquisition of resources for the various departments and sections, budgetary items and similar concerns.

10.4 Clinical Sections.

10.4.1 Creation. The Medical Executive Committee may recommend to the Governing Board the creation of new clinical sections of existing departments or the elimination or combination of an existing section for better organizational efficiency and improved patient care. Action taken by the Governing Board pursuant to this Article 10.4 shall be effective on such date as determined by the Governing Board and shall not require formal amendment of these Bylaws. Any section created or existing as such an exception must satisfy the functions of such section as required by Medical Staff policy.

10.4.2 Criteria and Functions. To become a section, a group of Practitioners must represent a distinct and specialized area of practice at the Hospital and demonstrate a special interest in, and be of sufficient size to conduct, the following clinical, administrative and quality review and utilization management, and collegial and education functions:

(a) Clinical Functions. Each section must:

(i) Establish, implement and monitor Medical Staff members' adherence to clinical standards, policies, procedures and practices relevant to the Clinical Privileges represented by its membership; and

(ii) Develop criteria for use in making credentials recommendations to the section chair on initial appointments, reappointments, granting of Clinical Privileges, and other credentials matters.

(b) Administrative Functions. Each section must make recommendations to the section chair concerning the short-term and long-term allocation and acquisition of resources to and provisions of services by the Hospital and the department.

(c) Quality Review/Professional Liability Prevention/Utilization Management. Each section must analyze quality review, professional liability prevention and utilization data and findings pertinent to the section and the department, and make recommendations to the section chair regarding same.

(d) Collegial and Education Functions. Each section shall serve and the most immediate peer group for:

(i) Providing clinical support among and between peers;

(ii) Teaching, research, continuing education and sharing new knowledge relevant to the practice of section members;

(iii) Planning for and supporting the provision and coordination of patient education activities; and

(iv) Providing consultative advice in its area to other Medical Staff members.

10.5 Section Chairs.

10.5.1 Qualifications. Each section chair shall be a member of the active staff or the contract staff who possesses, and for his or her term of office, maintain at all times, the same qualifications as those required of Medical Staff officers set forth in Article 9.1.2 of these Bylaws.

10.5.2 Appointment. Each section chair shall be appointed by the department chair of the department of which he or she is a Member.

10.5.3 Term of Office. The term of the section chair shall coincide with that of the department chair who recommends his or her appointment.

10.5.4 Removal. Removal of a section chair during his or her term of office may be initiated by the department chair, a two-thirds (2/3) vote of all active staff members in the section, the Medical Executive Committee or by the Governing Board on its own motion.

10.5.5 Vacancy. If there is a vacancy in the position of section chair, the department chair shall select another Medical Staff member possessing the qualifications set forth in Article 9.1.2 of these Bylaws to serve out the remainder of the unexpired term of such office. Such appointment shall be effective when approved by the section.

10.5.6 Section Chair Responsibilities and Duties. Each section chair shall:

(a) Be responsible for administrative activities within the section.

(b) Maintain continuing surveillance of the professional performance of all Medical Staff members who have delineated Clinical Privileges in the section.

(c) Recommend criteria for Clinical Privileges within the section.

(d) Review the professional performance of all Medical Staff members with Clinical Privileges in the section and report and recommend thereon to the department chair as part of the reappointment process and at such other times as may be indicated.

(e) Be responsible for enforcement within the section of Hospital policies and procedures, these Bylaws and Rules and Regulations.

(f) Be responsible for implementation within the section of actions taken by the Governing Board, the Medical Executive Committee and the department chair.

(g) Make reports to the department chair concerning the appointment and delineation of Clinical Privileges for all applicants seeking Privileges in the section.

(h) Be responsible for the establishment, implementation and effectiveness of the teaching, education and research program in the section.

10.6 Provisions Common to All Department and Section Meetings. Except as otherwise provided in these Bylaws, the following provisions shall apply to all department and section meetings.

10.6.1 Regular Meetings. Frequency of regular meetings shall be determined by the department or section chair. A department or section also shall meet whenever necessary or as requested by the Chief of Staff.

10.6.2 Special Meetings. A special meeting of any department or section may be called by or at the request of the Chief of Staff, the department or section chair or one-third (1/3) of the department or section members.

10.6.3 Attendance and Participation by Hospital Administration. The Chief Executive Officer, the President, the Chief Medical Officer or his designee, and Medical Staff, and any other individuals invited by such persons, shall be permitted to attend department or section meetings and participate in discussions, but not vote.

10.6.4 Agenda. The agenda for the meeting and its general conduct shall be set by the department or section chair.

10.6.5 Manner of Acting; Quorum; Voting. A quorum shall consist of one-third (1/3) of the department or section members. A simple majority of those members eligible to vote at a meeting at which quorum is present shall be sufficient to take action.

10.6.6 Reports and Minutes. Each department shall make reports concerning significant findings and recommendations of such department and its section(s), if any, as appropriate, to the Medical Executive Committee. Each section shall make reports concerning its recommendations to the department chair. Minutes of each department and section meeting shall be prepared and shall include a record of the attendance of members, the recommendations made and the votes taken on each matter. A permanent file of the minutes shall be maintained by each committee.

10.6.7 Attendance. Each department and section member is expected to attend regular and special meetings unless excused by reason of illness, planned absence, or a medical or personal emergency. Unless reason is provided to the Hospital medical staff office prior to approval of the minutes at the first meeting following the meeting that was missed, the absence will be deemed unexcused. The number of excused and unexcused absences will be evaluated as part of each department or section member's reappointment or more frequently, if circumstances so warrant.

ARTICLE ELEVEN

MEDICAL STAFF COMMITTEES

11.1 Standing Committees of the Medical Staff. The standing committees of the Medical Staff shall be the Medical Executive Committee, the Credentials Committee, the Nominating Committee, the Medical Staff Health Committee, the Bylaws Committee and the Quality Committee.

11.2 Medical Executive Committee.

11.2.1 Composition. The Medical Executive Committee shall consist of the following members who shall serve *ex officio*:

(a) Chief of Staff, with vote;

(b) Vice Chief of Staff, with vote;

(c) Each department chair, with vote; and

(d) Chair of Credentials Committee, without vote.

11.2.2 Attendance and Participation by Hospital Administration. The Chief Executive Officer, the President, and the Chief Medical Officer or his designee shall serve as *ex officio* members of the Medical Executive Committee, without vote. These individuals shall be permitted, with approval of the Chief of Staff, to invite other members of the administrative staff or members of the Governing Board to attend meetings and participate in discussions, but not to vote.

11.2.3 Quorum. For regular and special meetings of the Medical Executive Committee, a quorum shall consist of one-half (1/2) the total number of voting members.

11.2.4 Duties. The duties and authority of the Medical Executive Committee are to:

(a) Represent and act on behalf of the Medical Staff in all matters between Medical Staff meetings, without requirement of subsequent approval by the Medical Staff, except as otherwise provided in these Bylaws. All action taken by the Medical Executive Committee on behalf of the Medical Staff shall be presented at the next regularly scheduled Medical Staff meeting.

(b) Be responsible for the organization of the performance improvement activities of the Medical Staff and implementation of the Hospital's quality improvement plan as it affects the Medical Staff.

(c) Monitor the mechanism used to conduct and evaluate quality improvement activities.

(d) Receive and act on reports and recommendations from Medical Staff committees, departments and assigned activity groups, and make recommendations concerning the reports to the Chief Executive Officer, the Chief Medical Officer, or the President, or their designee, and the Governing Board.

(e) Implement and enforce Hospital and Medical Staff Bylaws, policies and procedures and Rules and Regulations in the best interest of patient care and the Hospital, with regard to all persons who hold appointment to the Medical Staff.

(f) Act as a liaison among the Medical Staff, the Chief Executive Officer, the Chief Medical Officer and the Governing Board.

(g) Keep the Medical Staff apprised of applicable accreditation and regulatory requirements affecting the Hospital.

(h) Review all information available regarding the performance and clinical competence of Practitioners who hold appointments to the Medical Staff and, as a result of such review, take any of the following actions:

(i) Recommend to the Governing Board terminations and revisions of Medical Staff members' Clinical Privileges and Medical Staff membership;

(ii) Request evaluations of Medical Staff members' performances and clinical competence to determine Practitioners' abilities to perform Clinical Privileges granted or requested; and

(iii) Take any other action deemed appropriate considering the particular circumstances.

(iv) Be responsible for making recommendations directly to the Governing Board for its approval, which pertain to at least the following:

(v) Medical Staff structure;

(vi) Mechanisms used to review credentials and to delineate individual Practitioner's Clinical Privileges;

(vii) Recommendations of Practitioners for Medical Staff membership;

(viii) Recommendations of Practitioners for delineated Clinical Privileges;

(ix) 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;

(x) The mechanism by which Medical Staff membership may be terminated; and

(xi) The mechanism for fair-hearing procedures.

11.2.5 Meetings and Reporting. The Medical Executive Committee shall meet no less than 9 times per year, or more often if necessary to transact business. The Medical Executive Committee shall communicate its discussions and actions that affect or define Medical Staff policies, rules or positions by monthly minutes made available to all members of the Medical Staff. The Medical Executive Committee's other reporting

obligations are as stated in the various Articles of these Bylaws and, in addition, copies of its minutes and reports shall be forwarded to the Chief Executive Officer, Chief Medical Officer, or the President and, as appropriate or as required, to the Governing Board.

11.3 Credentials Committee.

11.3.1 Composition. The Credentials Committee shall be composed of no less than five (5) members with no less than three (3) of them being Past Chiefs of Staff that maintain staff membership. No less than three (3) members will be from the Active staff membership category. In the event of a vacancy on the committee, replacements will be obtained from the list of Past Chiefs of Staff or other interested members of the medical staff. The Credentials Committee shall appoint its own chair by majority vote of its members.

11.3.2 Duties. The duties of the Credentials Committee shall be to:

(a) Conduct the Medical Staff function of credentialing in a thorough, efficient and fair manner that serves the best interests of the Medical Staff and the patients of the Hospital;

(b) Make credentialing recommendations to the Medical Executive Committee on individual applications for membership and Privileges;

(c) Develop specific Clinical Privilege criteria as appropriate;

(d) Investigate quality issues as directed by the Medical Executive Committee, department chair, President or Chief Medical Officer;

(e) Offer guidance to department chairs as appropriate; and

(f) Conduct interviews as needed.

11.4 Nominating Committee.

11.4.1 Composition. The Nominating Committee shall consist of the two (2) most recent Immediate Past Chiefs of Staff, who are active staff members and the present Chief of Staff.

11.4.2 Duties. The duties of the Nominating Committee are to:

(a) Serve as a nominating committee for Medical Staff elections;

(b) Select a qualified member of the Medical Staff to serve in each open Medical Staff officer position; and

(c) Transmit this slate to the Medical Executive Committee for receipt and publishing.

11.5 Medical Staff Health Committee.

11.5.1 Composition. The composition and specific duties of the Medical Staff Health Committee shall be described in the Medical Staff Health Issues Policy, which shall be approved by the Medial Executive Committee and the Governing Board.

11.5.2 Duties. The Medical Staff Health Committee shall implement a process to identify and manage matters of individual Medical Staff member health. In performing this function, the Medical Staff Health Committee shall have the following responsibilities:

(a) Provide assistance to those members of the Medical Staff who, because of a physical, emotional or mental impairment, are in need of assistance and monitoring in order to gain restoration of optimal professional functioning and be able to provide satisfactory patient care.

(b) Educate Medical Staff members and other staff about illness and impairment recognition and the process for self-referral or confidential referral by others.

(c) Develop mechanisms for the self-referral or the confidential referral by others of impaired Medical Staff members to the Medical Staff Health Committee, which shall arrange for appropriate professional internal and external resources for evaluation, diagnosis and treatment of health issues.

(d) Ensure the confidentiality of any Medical Staff member who seeks referral or is referred for assistance, except as limited by law, ethical obligation or when the health and safety of a patient is threatened.

(e) Establish a process for evaluating the credibility of a complaint, allegation or concern regarding an individual Medical Staff member's health.

(f) Develop effective means of monitoring impaired Medical Staff members to ensure the safety of patients until the rehabilitation or any disciplinary process is complete and, thereafter, periodically as needed.

(g) Design appropriate procedures for reporting to the Medical Staff instances in which an impaired Medical Staff member is providing unsafe treatment.

11.6 Bylaws Committee.

11.6.1 Composition. The Bylaws Committee shall consist of the Vice Chief of Staff, a member of the Credentials Committee and additional members recognized as experienced Medical Staff leaders by the current Chief of Staff. The Vice Chief of Staff shall serve as chair of the Bylaws Committee during the second year of his or her two year term. For all other years, the Bylaws Committee shall elect an interim chair at the first meeting of the fiscal year of the Hospital. The Chief Executive Officer, the President and the Chief Medical Officer, shall serve as *ex officio* members, without vote, of the Bylaws Committee.

11.6.2 Duties. The duties of the Bylaws Committee are to:

(a) Conduct a review at least every two (2) years of these Bylaws, the Rules and Regulations and department rules for continuing adequacy to implement Medical Staff functions;

(b) Submit recommendations to the Medical Executive Committee for changes in Bylaws or the Rules and Regulations;

(c) Consider matters pertinent to the Bylaws, Rules and Regulations or credentialing policies submitted from any source;

(d) Meet as required by the chair, but not less than once a year;

(e) Evaluate requests for legal opinions received from the Medical Executive Committee by:

(f) Researching available resources for relevant published opinions;

(g) Isolating the precise issues requiring a legal opinion; and

(h) Formulating narrowly focused questions that will address the perceived need for legal advice;

(i) Report back to the Medical Executive Committee the results of the evaluation of requests for legal opinions for its consideration, with an estimate of costs involved; and

(j) In the event a legal opinion is sought, act as a resource for the attorneys to help shape an appropriate response.

11.7 Quality Committee.

11.7.1 Composition. The Quality Committee shall be composed of a multidisciplinary group of providers representing KHS. Appointment will be made by the Chief of Staff and the Chief Medical Officer. The Medical Executive Committee will review and approve these appointments. A minimum of five members will be on the committee. The Chief Medical Officer will chair and be a voting member of this committee. Each member shall serve a three (3) year term. Members shall be eligible for one consecutive term.

Non-voting members shall include the Vice President of Patient Care, Director of Quality, Director of Risk Management and the President and/or his or her designee and others as appointed by the Chief Medical Officer.

The Chair in conjunction with the Chief of Staff will have the ability to appoint members of the Medical staff outside of the committee as needed to create sub committees that may address any quality initiatives.

11.7.2 Responsibilities. The Quality Committee provides effective mechanisms to monitor and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. Important problems in patient care are identified, and opportunities to improve patient care are addressed through the following specific functions:

(a) Coordinate, prioritize and monitor the Medical Staff data gathering and analysis components of Hospital's quality review program including, without limitation, annually reviewing and approving various clinical indicators used to benchmark, measure and evaluate care quality that are recommended by departments, hospital management, the Medical Executive Committee and any regulatory bodies.

(b) Review and evaluate on a regular basis quality reports generated by Hospital, clinical departments and hospital performance improvement committees.

(c) Participate in the establishment, approval and modification of the Hospital performance improvement plan by Hospital representatives.

(d) Monitor trends and significant events identified by quality monitoring and review programs related to Medical Staff activities and develop action plans to address any concerns as needed.

(e) Review and address safety reports, or other significant quality events in a standardized process, that relate to the performance of any Medical Staff member.

(f) Review and evaluate the quality of patient care provided by individual Medical Staff members and, to the extent performance improvement actions recommended by the Committee may impact a Medical Staff member's membership or clinical privileges, refer the matter to the appropriate department chair and the Credentials Committee for action.

(g) Oversee case management and utilization review responsibilities.

(h) Makes recommendation for modification in quality activities to improve patient care.

(i) Refer any quality concerns identified that relate to Hospital performance to the appropriate Hospital committee.

(j) Provide summary reports of all quality concerns, including quality monitoring data and performance improvement actions plans, to the Medical Executive Committee at least annually or more often as necessary.

(k) Serve as a multidisciplinary team that performs peer review. Review peer review cases from Medical Staff departments as requested and is protected under the immunity protection as described in the Bylaws,

11.7.3 Case Management/Utilization Review. The Quality Committee shall be responsible for Case Management and Utilization Review, which shall include:

(a) Conducting utilization review studies, including Medical Care Evaluation Studies, designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and all related factors which may contribute to the effective utilization of hospital and physician services. Outside consultants and resources may be used by the committee to analyze the utilization and quality of patient care provided at the Hospital. Patterns relating to average lengths of stay by specific disease categories, medical necessity of extended stays, appropriateness of the patient care setting, denials and utilization review criteria may be evaluated. The Quality Committee shall also work toward the assurance of proper continuity of patient care upon discharge through use of outside resources and reports. The Quality Committee shall make recommendations for the optimum utilization of hospital resources and facilities commensurate with a high quality of patient care and safety.

(b) Formulating a written utilization review plan for the Hospital, which shall be approved by the Governing Board and include:

(i) the organization and composition of the committee which shall be responsible for the utilization review function;

(ii) determining the frequency of meetings;

(iii) determining the types of records to be kept;

(iv) determining the method to be used in selecting cases on a sample or other basis;

(v) determining what constitutes the period of extended duration;

(vi) arrangements for creation of committee reports and their dissemination; and

(vii) responsibilities of the hospital's administrative staff in support of utilization review.

11.7.4 Admission and Discharge. The Quality Committee shall be responsible for evaluating admission and discharge issues, including reviewing the medical necessity for continued or terminated hospital services for particular patients and patient census information and elective surgery information. In making such evaluations, the committee shall be guided by the following criteria:

(a) no physician shall have review responsibility for any extended stay cases in which he or she is or has been professionally involved;

(b) all decisions that an extended inpatient stay is not medically necessary shall be made by physician member(s) of the committee and only after an opportunity for the attending physician to present her/his views, and full consideration has been given to the availability of hospital facilities and services; and

(c) in the case of a significant divergence in opinion following consultation regarding the medical necessity for continued inpatient services for the patient, the judgment of the attending physician shall be given considerable weight.

A second physician member of the Quality Committee will review and consult the practitioner(s) responsible for the care of the patient. The final decision will be made by the second physician member of the Quality Committee.

11.7.5 Medical Records. The Quality Committee shall be responsible for reviewing the quality of medical records at least quarterly for clinical pertinence and timely completion. The medical record review function assures that each medical record, or a representative sample of medical records, reflects the appropriate diagnosis, results of diagnostic tests, therapy rendered, condition and in hospital progress of the patient, condition of the patient at discharge, and includes a review of summary information regarding the timely completion of all records.

11.8 Creation and Dissolution of Other Committees.

11.8.1 Creation. The Medical Executive Committee may from time to time establish, without amendment of these Bylaws, additional committees to perform one or more Medical Staff function.

11.8.2 Dissolution. The Medical Executive Committee may dissolve or rearrange the structure, duties or composition of such committees as needed to better accomplish Medical Staff functions.

11.9 Provisions Common to All Medical Staff Committees. Except as otherwise provided in these Bylaws, the following provisions shall apply to all Medical Staff committees.

11.9.1 All committees of the Medical Staff, other than the Medical Executive Committee, shall be advisory, to and report directly to, the Medical Executive Committee.

11.9.2 Regular Meetings. Frequency of regular meetings shall be determined by the committee chair. A committee also shall meet whenever necessary or requested by the Chief of Staff.

11.9.3 Special Meetings. A special meeting of any committee may be called by the Chief Medical Officer, or at the request of, the Chief of Staff, the committee chair or one-third (1/3) of the committee members.

11.9.4 Attendance and Participation by Hospital Administration. The Chief Executive Officer, the President, the Chief Medical Officer, and any other individuals

invited by such persons shall be permitted to attend Medical Staff committee meetings and participate in discussions, but not vote.

11.9.5 Agenda. The agenda for the meeting and its general conduct shall be set by the committee chair.

11.9.6 Manner of Acting; Voting.

(a) Unless otherwise specified, a quorum consists of two or more of assigned Medical Staff members A simple majority of those members eligible to vote at a meeting in which quorum is present shall be sufficient to take action.

(b) Only committee members who are Medical Staff members shall have voting privileges unless otherwise specified. Hospital administrative representatives shall serve as nonvoting, *ex officio* members of Medical Staff committees unless otherwise specified.

11.9.7 Reports and Minutes. Each committee shall make reports concerning significant findings and recommendations thereof, as appropriate, to the Medical Executive Committee. Minutes of each committee meeting shall be prepared and shall include a record of the attendance of members, the recommendations made and the votes taken on each matter. A permanent file of the minutes shall be maintained by the Medical Staff Office.

11.9.8 Attendance. Each committee member is expected to attend committee meetings on which he or she serves unless excused by reason of illness, planned absence or a medical or personal emergency. Unless reason is provided to the Hospital medical staff office prior to approval of the minutes at the first meeting following the meeting that was missed, the absence will be deemed unexcused. The number of excused and unexcused absences will be evaluated as part of each committee member's reappointment or more frequently, if circumstances so warrant. Continued failure to attend committee meetings may result in removal from the committee.

11.9.9 Disclosure of Conflicts of Interest or Bias. Each committee member shall disclose any Conflict of Interest or bias that the committee member may have with respect to any matters being discussed or reviewed by the committee. If a Conflict of Interest or bias exists, the committee chair shall be responsible for addressing the conflict.

11.9.10Committee Composition. A Medical Staff committee created pursuant to these Bylaws may include, when appropriate, representatives from hospital departments as are appropriate to the committee function(s) to be discharged. Each designated member of a committee participates with a vote, unless the statement of committee composition or these Bylaws designates the position as nonvoting. The Chief of Staff and the Chief Executive Officer or President, Chief Medical Officer, or their respective designees, shall be nonvoting, *ex officio* members of all standing and special committees of the Medical Staff unless otherwise specified.

11.9.11Appointment and Term of Committee Members. Except as otherwise expressly provided, the Chief of Staff appoints, subject to the approval of the

Medical Executive Committee, the members of Medical Staff committees. Initial appointments of committee members shall be for a term of one (1) year, after which a committee member may be reappointed for an unlimited number of terms which shall be at least one year in length. Where necessary to accomplish a function or task assigned to a committee, the committee chair may call on outside consultants or special advisors from clinical specialties or administrative or patient care departments with expertise in the subject matter involved, after consultation with the Chief Executive Officer, the Chief Medical Officer or his or her designee. Appointments of non-Medical Staff members are subject to the approval of the Chief Medical Officeror his or her designee.

11.9.12Committee Member Removal, Resignation and Filling of Vacancies. Except for *ex officio* members, the Chief of Staff, after consulting with the President or Chief Medical Officer, may remove any committee member after consultation with the committee chair. The Chief Executive Officer, the President, Chief Medical Officer, or the Governing Board may remove a committee member for failure to meet any qualification for membership only after consulting with the Chief of Staff and the committee chair. Any committee member may resign at any time by giving written notice to the Medical Executive Committee. Such resignation takes effect on the date of receipt or at any other time specified in the resignation. The Chief of Staff shall fill any vacancies that arise in committee membership positions.

11.9.13Committee Chairs. Each committee chair or other authorized person chairing a meeting has the right to participate in discussion of and to vote on issues presented to the committee.

(a) Appointment. Except as otherwise provided in these Bylaws or any Medical Staff policy, the Chief of Staff shall appoint committee chairs.

(b) Term. Except as otherwise provided in these Bylaws, initial appointments of committee chairs shall be for a period of one (1) year, after which a chair may be reappointed.

(c) Removal.

(i) The Chief of Staff, after consulting with the Chief Medical Officer, may remove a committee chair for any reason.

(ii) The Chief Executive Officer, the President, Chief Medical Officer, or the Governing Board may, after consulting with the Chief of Staff, remove a committee chair for failure to carry out his or her responsibilities.

(d) Resignation. Any committee chair may resign at any time by giving written notice to the Medical Executive Committee. Such resignation takes effect on the date of receipt or at any other time specified in the resignation.

(e) Vacancies. In the event a committee chair position becomes vacant, the Chief of Staff shall appoint a qualified active or contract staff member to assume all duties and responsibilities of the position.

(f) Action through Subcommittees. Any Medical Staff committee may elect to perform any of its specifically designated functions by constituting a subcommittee for that purpose, provided that it reports such action to the Medical Executive Committee in writing. Any such subcommittee may include individuals in addition to, or other than, members of such committee. Such additional members are appointed by the committee chair after consultation with the Chief of Staff, in the case of Medical Staff members, and with the approval of the Chief Executive Officer or the President, Chief Medical Officer, or his or her designee, when administrative staff appointments are to be made.

ARTICLE TWELVE

MEDICAL STAFF MEETINGS

12.1 Medical Staff Meetings.

12.1.1 Regular Meetings.

(a) Regular meetings of the Medical Staff shall be scheduled at least annually, or more often as needed.

(b) The Medical Staff may call itself into executive session at any time during a regular or special meeting. Accurate minutes must be kept of any actions taken during executive sessions.

12.1.2 Annual Meeting.

(a) The annual meeting of the Medical Staff shall be near the second Tuesday of the last month of the fiscal year of the Hospital.

(b) At this meeting, officers shall be elected and recommendations for the various committees and departments shall be made, when applicable.

12.1.3 Special Meetings. The Chief of Staff may call a special meeting of the Medical Staff at any time. He or she shall also call a special meeting if requested by the Governing Board, the Chief Medical Officer, the Medical Executive Committee, the Chief Executive Office, the President, the Chief of Staff or a petition signed by one-third (1/3) of the members of the active staff who are in Good Standing. At any special meeting, no business shall be transacted except that business stated in the notice calling the meeting. Sufficient notice of any meeting shall be a notice posted at least 48 hours before the time set for the meeting.

12.1.4 Attendance and Participation by Hospital Administration. The Chief Executive Officer, the President, the Chief Medical Officer and Medical Staff, and any other individuals invited by such persons, shall be permitted to attend Medical Staff meetings and participate in discussions, but not vote.

12.2 Quorum. The presence of one-half (1/2) of the qualified voting members of the active Medical Staff at any regular or special meeting constitutes a quorum for the transaction of any business under these Bylaws.

12.3 Minutes. Minutes of each meeting of the Medical Staff shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and copies distributed to members at each meeting, as appropriate. Original copies of all minutes shall be maintained by the Medical Staff Office.

12.4 Rules of Order. Whenever they do not conflict with these Bylaws, the currently revised Robert's Rules of Order shall govern all meetings.

12.5 Attendance Requirements.

12.5.1 General. Each member of the Active and Associate Staff is expected to attend the Medical Staff meetings, meetings of his or her department and meeting of committees on which he or she serves, unless excused by reason of illness, absence from the city or a medical or personal emergency. Unless reason is provided to the Hospital medical staff office prior to approval of the minutes at the first meeting following the meeting missed, the absence will be deemed unexcused. The number of excused and unexcused absences will be evaluated as part of each Staff member's credentialing process, or more frequently, if circumstance so warrant.

12.5.2 Penalties for Failure to Attend Meetings. Unexcused absences by an active or associate Staff member at more than one-half of required meetings of a department, committee, section or the Medical Staff in any credentialing cycle results in:

(a) A one-year probationary period for the first occurrence in a credentialing cycle;

(b) A one-week suspension and additional one-year extension of the probationary period for the second occurrence in a credentialing cycle; or

(c) A two-week suspension and additional one-year extension of the probationary period for the third occurrence in a credentialing cycle.

ARTICLE THIRTEEN

CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 Authorizations and Conditions. By applying for or exercising Clinical Privileges or providing specified patient care services within the Hospital, a Practitioner:

13.1.1 Authorizes and agrees to execute authorizations or releases as requested by Hospital Representatives to solicit, provide and act upon information bearing on his or her professional ability and qualifications from any Third Party who may have information pertaining to the Practitioner's professional qualifications, credentials, clinical

competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter reasonably having a bearing on the Practitioner's satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization shall cover the right to inspect or obtain any communication, report, record, statement, document or recommendation of said Third Party. The Practitioner also specifically authorizes said Third Party to release the information to the Hospital and any Hospital Representative upon request. Failure to execute additional authorizations requested by the Hospital shall be grounds to discontinue processing a pending application or, if the Practitioner is a Medical Staff member, such refusal shall constitute a voluntary relinquishment of his or her Medical Staff membership without any procedural rights hereunder.

13.1.2 Agrees to be bound by the provisions of Article Thirteen of these Bylaws and to waive all legal claims against any Hospital Representative who acts in accordance with the provisions of this Article Thirteen.

13.1.3 Acknowledges that the provisions of Article Thirteen of these Bylaws are conditions to his or her application for, or acceptance of, professional staff membership and the continuation of such membership, or to his or her exercise of Clinical Privileges or provisions of specified patient services in the Hospital.

13.1.4 Consents to the presence of Hospital Representatives at any meeting of the Medical Staff or any committee, subcommittee or ad hoc committee of the Medical Staff and authorizes the disclosure of any and all peer review information set forth in the Practitioner's credentials file, any reports prepared by the Hospital in connection with any peer review activity and any other information regarding the Practitioner among the Hospital, KHS and other hospitals operated by KHS at which the Practitioner has applied for or attained Medical Staff membership. Any peer review information released pursuant to this Article shall be treated as confidential by the entity receiving such information in accordance with applicable law. To the extent that information to be released contains patient health care information, the Hospital shall, when required to do so by law, take any and all actions to de-identify such information prior to release.

13.1.5 Specifically authorizes the Hospital, and any Hospital Representative, to release any and all peer review information to other hospitals, health care facilities and their agents who solicit such information for the purpose of evaluating the Practitioner's professional qualifications pursuant to a request for appointment, reappointment and Clinical Privileges.

13.2 Confidentiality of Information. Information with respect to any Practitioner submitted, collected or prepared by any Hospital Representative, or any other health care facility or organization or Medical Staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, contributing to teaching or clinical research, determining that health care services are professional, were indicated or were performed in compliance with the applicable standard of care, or establishing guidelines to keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Hospital Representative, the Hospital, KHS, and other hospitals operated by KHS at which the Practitioner has applied for or attained Medical Staff

membership. Any peer review information released pursuant to this Article shall be treated as confidential by the entity receiving such information in accordance with applicable law. To the extent that information to be released contains patient health care information, the Hospital shall, when required to do so by law, take any and all actions to de-identify such information prior to release.

13.3 Immunity and Release from Liability.

13.3.1 To the fullest extent permitted by law and as an express condition of seeking appointment or reappointment to the Medical Staff, the Practitioner releases from any and all liability, and extends absolute immunity to Hospital and all Hospital Representatives, with respect to any acts, recommendations, communications or disclosures involving the Practitioner that are taken in good faith and without malice in substantial compliance with the procedures set forth in these Bylaws. No Hospital Representative shall be liable to any Practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his or her duties if such person acts in good faith and without malice. No Hospital Representative and no Third Party shall be liable to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to any other Hospital Representative or to any to other health care facility or organization of health professionals concerning a Practitioner who did or does exercise Clinical Privileges at the Hospital, provided that such Hospital Representative acts in good faith and without malice.

13.3.2 Activities and Information Covered. The confidentially and immunity provided by Article Thirteen of these Bylaws and the Immunity Provisions shall apply to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements or disclosures performed or made in connection with the Hospital's activities or any other health care facility's or organization's activities concerning but not limited to:

(a) Applications for initial or reappointment requests;

(b) Periodic reappraisals for reappointments, Clinical Privileges or specified services;

(c) Corrective action or disciplinary action;

(d) Hearings and appellate reviews;

(e) Patient or medical care audits;

(f) Utilization reviews;

(g) Claims reviews;

(h) Malpractice loss prevention;

(i) Other Hospital, department, committee or professional staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(j) Any release of information made pursuant to this Article Thirteen or any other Articles of these Bylaws.

The acts, communications, reports, recommendation, disclosures and other information referred to in this Article Thirteen of the Bylaws may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics or any other matter that might directly or indirectly affect patient care.

13.4 Releases. Each Practitioner shall, upon the good faith request of the Hospital made in substantial compliance with these Bylaws, execute general and specific releases in accordance with the tenor and import of this Article Thirteen of these Bylaws, subject to such requirements, including those of good faith and absence of malice, as may be applicable under the laws of the State of Illinois. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article Thirteen of these Bylaws.

13.5 Cumulative Effect. Provisions in these Bylaws, and in application forms relating to authorizations, confidentiality of information and immunities from liability, shall be in addition to other specifications provided by law and not in limitation thereof, and in the event of conflict, the applicable law shall be controlling.

13.6 Indemnification.

13.6.1 By a Practitioner. Practitioner shall indemnify and hold harmless the Hospital, any Hospital Representative and any Third Party from any claims, liabilities, costs and expenses including, without limitation, reasonable attorney's fees and costs incurred in defending against any claim or action released by Practitioner pursuant to these Bylaws.

13.6.2 By KHS and/or the Hospital. To the extent that a Medical Staff member who (i) is serving as an officer of the Medical Staff, serving as a Medical Staff committee chair, or performing a quality assessment or peer review activity pursuant to these Bylaws at the request of an officer, a Medical Staff committee chair or the Hospital; or (ii) is or was serving as a member of any committee duly constituted under these Bylaws or the Rules and Regulations, or the other committees created by action of the Medical Staff or the Hospital's Governing Board has been successful on the merits or otherwise in the defense of a legal proceeding (including, without limitation, the settlement, dismissal, abandonment or withdrawal of any action where he or she does not pay or assume any material liability), or in connection with any claim, issue or matter therein, KHS and/or the Hospital shall indemnify such Medical Staff member for expenses actually incurred by him or her in connection with such proceeding to the extent that he or she was a party to the proceeding because of his or her responsibilities as an officer of the Medical Staff or a member of a Medical Staff committee or otherwise engaged in activities provided for or

required of Medical Staff members by these Bylaws, policies or procedures of the Governing Board or by law. The indemnification provided for in this Article 13.6.2 of these Bylaws is not intended to extend to any Medical Staff member's individual actions or activities that occur outside authorized or appropriate Medical Staff responsibilities or activities. KHS and/or the Hospital is further authorized, upon written request by such an officer or committee member who is named as a party in any claim or litigation, to pay or reimburse such Medical Staff member's reasonable expenses as incurred if the Medical Staff member provides KHS and/or the Hospital with the following:

(a) A written affirmation of the Medical Staff member's good faith belief that he or she has not breached or failed to perform duties owed to the Hospital; and

(b) A written acknowledgement to repay to KHS and/or the Hospital expenses reimbursed or advanced if it is found that indemnification provided for under these Bylaws would not have been provided by KHS and/or the Hospital as permitted or required.

13.6.3 Discretionary Indemnification by KHS and/or the Hospital. In cases not included under Article 13.6.2, and in addition to any reimbursement of expenses incurred, KHS and/or the Hospital may indemnify any Medical Staff member described in Article 13.6.2 above against liability incurred by such Medical Staff member in a proceeding to which the Medical Staff member was a party because of his or her position as a Medical Staff officer or member of a Medical Staff committee, unless liability was incurred because the Medical Staff member breached or failed to perform a duty he or she owes to KHS and/or the Hospital and the breach or failure to perform constitutes any of the following:

(a) A willful failure to deal fairly with anyone, including the Hospital, its directors, officers, employees, agents, other Medical Staff members or Practitioners, in connection with a matter in which the Medical Staff member has a Conflict of Interest as defined in these Bylaws and in any policies adopted by the Governing Board;

(b) A violation of any federal, state or local law, unless the Medical Staff member had reasonable cause to believe his or her conduct was lawful or no reasonable cause to believe his or her conduct was unlawful;

(c) A transaction from which the Medical Staff member derived an improper personal profit; or

(d) Willful misconduct.

Indemnification under this Article 13.6.3 is not required to the extent that a Medical Staff member described in Article 13.6.2 above has previously received or has entitlement to indemnification, reimbursement or allowance of expenses or payment for liability responsibility from any party, including insurance companies or KHS and/or the Hospital, in connection with the same proceeding.

13.6.4 Purchase of Insurance. KHS and/or the Hospital may, in its sole discretion, purchase and maintain insurance on behalf of itself and any Medical Staff

member who currently is or was a member of the Medical Staff, to the extent that such Medical Staff member is insurable and such insurance coverage can be secured by KHS and/or the Hospital at rates and in amounts and subject to such terms and conditions as shall be determined in good faith to be reasonable and appropriate by the Governing Board, and whose determination shall be conclusive, against liability asserted against or incurred by him or her in any such capacity or arising out of his or her status as such, whether or not KHS and/or the Hospital would have the power to indemnify him or her against such liability under the provisions of these Bylaws.

ARTICLE FOURTEEN

HISTORY AND PHYSICAL

14.1 General Requirements. The attending Practitioner is responsible for the history and physical which may be completed no more than 30 days prior to admission or 24 hours after admission. An original or durable legible copy of the office history and physical is acceptable but must be updated, signed, dated, since the date of the visit. An updated entry must be made in the medical record that documents an examination of any changes in the patient's condition, within 24 hours of admission or prior to surgery. The update to the history and physical can be updated by anyone who has privileges to perform a history and physicals. For patients admitted for outpatient surgery, the short form History and Physical may be used following the above stated timeframes.

14.1.1 The medical history shall include the following:

(a) the chief complaint,

(b) details of the present illness,

(c) relevant past, social and family histories (appropriate to the patient's age),

(d) an inventory by body systems,

(e) a report of the physical examination,

(f) a statement on the conclusions or impressions drawn from the history and physical examination;

(g) a statement on the course of action planned

14.1.2 Newborn and Pediatrics. The medical history for newborns and pediatric patients shall also include of immunization status when known.

14.1.3 Obstetrics. The medical history and physical for obstetrical patients shall also include the following:

(a) Prenatal information.

(b) An original or a durable legible reproduction of the office or clinic prenatal record, or electronic access is acceptable, but must be updated, signed and dated, since the last office visit. An admitting progress note with reference to the prenatal course, fetal heart tones, and any other pertinent prenatal information is acceptable.

(c) The Practitioner performing the delivery will include a post-delivery note in the medical record

(d) All patients who abort should have a record of blood type on the chart to ascertain the need for RhoGAM

14.1.4 Surgery/Special Procedures. A history and physical examination or an update to a history and physical examination completed within 30 days are a prerequisite to surgery and special procedures. A History and Physical must be present on the chart prior to the surgery or procedure (exception; local procedure). If the history and physical is dictated and not present on the medical record before surgery or procedure, a summary noting any recent health problems and any pertinent medical/surgical history must be in the patient's record. The responsible Practitioner shall record a pre-operative diagnosis and reason for the operation in the progress note prior to the surgery or procedure. A short form History and Physical may be utilized only for outpatients admitted for surgery, local procedures or procedures requiring moderate sedation. Any preoperative requirements may be waived if, in the judgment of the attending or Practitioner performing the operation/procedure, the risk of delay endangers the patient's life. Patients admitted primarily for dental treatment, or podiatric care must have a history and physical performed and authenticated by a member of the Medical Staff. This Practitioner will be privileged to treat and be responsible for all medical problems and treatment modalities during the course of hospitalization. A History & Physical describing the patient's dental/podiatric problems must also be included in the record by the responsible dentist/podiatrist. Oral-maxillofacial surgeons who admit patients without medical problems may perform the medical history and physical examination on those patients, if they have such privileges, and may assess the medical risks of the proposed surgical and/or other invasive procedure(s).

ARTICLE FIFTEEN

CONFLICT OF INTEREST PROVISIONS

Any Medical Staff member with actual knowledge of a potential conflict shall raise the purported or possible Conflict of Interest issue with the committee chair and present the factual basis for raising the purported or possible Conflict of Interest. Medical Staff members shall abide by the decision of the appropriate Medical Staff leadership or authority as to whether a disqualifying Conflict of Interest exists. It is presumed for the purpose of these Bylaws that members of the same medical specialty and those serving on committees may, to a limited degree, possess an element of professional competition with each other. This fact, by itself, will not presume the existence of a Conflict of Interest for the purposes of these Bylaws. As a matter of procedure, the committee chair designated to make a Conflict of Interest review shall inquire, prior to any discussion of the matter, whether any committee member has any Conflict of Interest or bias.

In any instance where a Medical Staff officer, committee chair, or a member of any Medical Staff committee has, or reasonably could be perceived to have, a Conflict of Interest or be biased in any matter involving another Medical Staff member that comes before such Medical Staff member or committee, or in any instance where a Medical Staff member or committee member responsible for bringing the complaint against a Medical Staff member is serving as a committee member of the body charged with, or in a capacity which requires, the review of such complaint, such Medical Staff member or committee member shall not participate in the discussion or voting on the matter. Such Medical Staff member shall be excused from any meeting during that time in which the matter is being deliberated on or acted upon, although the Medical Staff member or committee member may be asked, and may answer, any questions concerning the matter before leaving.

ARTICLE SIXTEEN

KISH*HEALTH* SYSTEM CODE OF CONDUCT

In accordance with the Office of Inspector General the KHS Code of Conduct policy shall be part of these Bylaws, and may be adopted, amended in accordance with Article 18 of these Bylaws. KHS expects each person to whom this Code of Conduct applies to abide by the principles set forth herein and to conduct the business and affairs of KHS in a manner consistent with these principles.

Nothing in this Code of Conduct is intended to nor shall be construed as providing any additional employment or contract rights to our Employees or others.

While KHS will generally attempt to communicate changes concurrent with or prior to the implementation of any changes, KHS reserves the right to modify, amend or alter the Code of Conduct without notice. The Code of Conduct and any changes thereto, shall become effective only when approved by the Governing Board. See Appendix A.

ARTICLE SEVENTEEN

MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff shall adopt Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These 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. The Rules and Regulations shall be part of these Bylaws, and may be adopted, amended in accordance with Article Seventeen of these Bylaws. The Rules and Regulations, and any changes thereto, shall become effective only when approved by the Governing Board.

ARTICLE EIGHTEEN

ADOPTION AND AMENDMENT

18.1 Adoption of Bylaws and/or Rules and Regulations. A proposal for adoption of these Bylaws and/or the Rules and Regulations may be submitted at any regular Medical Staff meeting. To be adopted, the Bylaws must be approved by two-thirds (2/3) of the active staff members present and voting at a duly convened meeting or by designated proxy vote, and the Governing Board. The Bylaws and Rules and Regulations, when adopted and approved, shall be equally binding upon all activities and actions of the Governing Board and the Medical Staff.

18.2 Amendments to the Bylaws and/or Rules and Regulations. Amendments to these Bylaws and/or the Rules and Regulations may be proposed by the Medical Executive Committee, the Medical Staff, the Bylaws Committee or the Governing Board as provided below. Amendments will be posted on line and in the medical staff physician lounge for review and comment for no less than thirty (30) days prior to vote at the Medical Staff Meeting. To be adopted, amendments must be approved by two-thirds (2/3) of the active staff members present and voting at a duly convened meeting or by designated proxy vote, and the Governing Board. Amendments made shall become effective only when approved by the Governing Board.

18.3 Medical Executive Committee. Amendments proposed by the Medical Executive Committee may, at the option of the Medical Executive Committee, be referred to the Bylaws Committee for consideration or may be forwarded directly to the Medical Staff for consideration. If referred to the Bylaws Committee, the Bylaws Committee shall report back to the Medical Executive Committee with its recommendation. After reviewing the recommendation of the Bylaws Committee, the Medical Executive Committee shall determine whether to forward the proposed amendment(s) to the Medical Staff for consideration. Amendments proposed in this manner may be submitted for consideration and approval at any meeting of the Medical Staff.

18.4 Medical Staff. Amendments may be proposed by the Medical Staff to the Governing Board if such amendments are approved by two thirds (2/3) of the Medical Staff who must be eligible to vote at Medical Staff meetings. All such amendments shall be presented by the Medical Staff to the Medical Executive Committee and the Medical Executive Committee shall have thirty (30) days to comment on any such amendments before submitting the same to the Governing Board for approval. Amendments proposed in this manner shall be presented for vote at the next regular Medical Staff meeting following receipt by the Medical Executive Committee of such petition.

18.5 Bylaws Committee. Amendments proposed by the Bylaws Committee shall be forwarded to the Medical Executive Committee for consideration. After receiving the recommendation of the Bylaws Committee, the Medical Executive Committee shall decide whether to recommend the proposed amendment(s) to the Medical Staff for consideration. If the Medical Executive Committee decides to recommend the amendment(s) proposed by the Bylaws Committee, such amendment(s) may be submitted for consideration and approval at any regular meeting of the Medical Staff.

18.6 Governing Board. Amendments proposed by the Governing Board shall be forwarded to the Medical Executive Committee for review and recommendation to the Medical Staff. The recommendation of the Medical Executive Committee shall be submitted, along with the proposed amendment(s), to the Medical Staff for consideration and approval at the next regular meeting of the Medical Staff.

18.7 Adoption and Amendment of Medical Staff Policies.

18.7.1 By the Medical Executive Committee. Medical Staff policies may be amended from time to time by the Medical Executive Committee upon approval of the Governing Board. The Medical Executive Committee shall notify the Medical Staff of the adoption and/or amendment of Medical Staff policies following their approval by the Governing Board.

18.7.2 By the Medical Staff. The Medical Staff may propose Medical Staff policies or amendments thereto to the Governing Board if such amendments and/or new policies are approved by two-thirds (2/3) of the Medical Staff who must be eligible to vote at Medical Staff meetings. All such amendments and new policies shall be presented by the Medical Staff to the Medical Executive Committee for comment. The Medical Executive Committee shall have thirty (30) days to comment on any such amendments before submitting the same of the Governing Board for approval.

18.8 Resolution of Disputes. In the event that a dispute arises between the Governing Board and the Medical Staff regarding the adoption or amendment of these Bylaws, the Governing Board shall create a Joint Conference Committee, half of the members of which committee shall be appointed by the Governing Board and the other half appointed by the Medical Staff. The Joint Conference Committee shall make attempts to resolve said dispute and shall provide its report and any recommendations to the Governing Board within the time frames prescribed by the Governing Board.

18.9 Construction. These Bylaws, along with the Rules and Regulations, shall serve as the guidelines for the governance, operations and discipline of the Medical Staff as may be necessary to implement the general principles found within these Bylaws in order to promote the delivery of quality health care within the Hospital and to provide for the efficient operation of the Hospital. These Bylaws shall be implemented and interpreted so as to meet all requirements for protection under the Immunity Provisions, including the adequate notice and hearing requirements of Section 412(b) of the Act.

18.10 Review of Bylaws. These Bylaws shall be reviewed every two years, or as indicated, by the Bylaws Committee.

ARTICLE NINETEEN

INVESTIGATIONS, PRECAUTIONARY SUSPENSIONS, AND CORRECTIVE ACTION PROCESS

19.1 Overview.

19.1.1 Scope. This Article sets forth the process by which the Medical Staff will handle requests for an Investigation (defined below) or the imposition of a precautionary suspension or corrective action . All activities conducted pursuant to this Article are Professional Review Activities. Nothing in this Article shall limit the ability of the Medical Staff, a Medical Staff Committee, a Medical Officer, the Hospital or any Hospital Representative to use informal mechanisms to address concerns related to the conduct, performance, or competence of a Practitioner. A Practitioner who is the subject of an Investigation request hereunder may, at any time, furnish to the Medical Staff Office, a written response to any action taken in connection with this Article Eighteen.

19.1.2 Coordination of Action. When any action taken under this Article with respect to a Practitioner who is a Medical Staff member of more than one facility within KHS, notice of such action shall be provided to the President, the Chief Medical Officer, Chief of Staff and Credentials Committee Chair of all other KHS facilities at which Practitioner is a Medical Staff member. As appropriate, joint meetings of any Medical Staff committees may be convened to address a matter affecting more than one facility.

19.2 Process and Criteria for Requesting an Investigation. Any person may provide information to a Medical Staff Officer, a Department Chair, the Chief Executive Officer, the Chief Medical Officer, the President, the Credentials Committee Chair, the Medical Executive Committee Chair, or the Governing Board Chair regarding the conduct, performance, or competence of a Practitioner. Whenever one of these individuals determines the information is credible and that such information raises a concern or question that a Practitioner with Clinical Privileges may have exhibited acts, demeanor, or conduct reasonably likely to be:

- detrimental to patient safety or to the delivery of quality patient care;
- unethical;
- contrary to these Bylaws, the Rules and Regulations, or the policies of the Medical Staff or the Hospital;
- below applicable professional standards of care, behavior or clinical management;
- disruptive, as defined in the Disruptive Provider Policy; or
- detrimental to the community's confidence in the Hospital; (including Hospital employees);

such individual shall submit to the Credentials Committee Chair a written request for an evaluation of the matter, which request shall describe the specific actions or conduct of concern. In the event that the information is provided directly to the Credentials Committee Chair, he or she shall create a written request documenting the specific actions or conduct of concern and proceed to evaluate such request in accordance with Article Eighteen of these Bylaws. The Hospital Medical Staff Office shall immediately send a copy of the request to the Practitioner, the President, the Chief Medical Officer. No written request shall constitute the initiation of an Investigation, as that term is defined below, unless and until the Credentials Committee determines that an Investigation shall be initiated.

19.2.1 Evaluation of Request for an Investigation. Initial Review of Concern or Question Raised by Request; Resources Available to Evaluate Request. In consultation with the Chief of Staff, the President, the Chief Medical Officer and, the Credentials Committee Chair shall, as soon as practicable, make sufficient inquiry to satisfy himself or herself that the concern or question is credible. The Credentials Committee Chair shall have available to him, her or it, the full resources of the Medical Staff and the Hospital to assist in evaluating the need/request for an Investigation, including, without limitation, the authority to use legal counsel or any other outside consultant and the ability to seek assistance from Hospital Representatives, legal counsel, outside consultants or any other appropriate party to gather information and interview witnesses in order to evaluate the credibility of the request.

19.2.2 Communication of Credibility Determination; Notification of Same.

(a) Credible Concern or Question. If the concern is credible, the Credentials Committee Chair shall refer the matter to the full Credentials Committee for review in accordance with Article Nineteen of these Bylaws.

(b) Concern or Question Lacks Credibility. If the Credentials Committee Chair determines that, based on available information, the request is not credible, he or she shall notify the Practitioner and the Credentials Committee of such conclusion in writing, with copies sent to the President, the Chief Medical Officer the Hospital Medical Staff Office and the full Credentials Committee.

(c) Concern or Question That Involves Matter of Practitioner Health. If the concern or question raised involves a matter of Practitioner health, handling of the request will depend upon which of the following three categories the matter falls within: (i) if the health issue in question has not previously been referred to the Medical Staff Health Committee, and the Credentials Committee Chair, in consultation with the President, the Chief Medical Officer , determines that the safety of patients or others is not in jeopardy, the Credentials Committee Chair shall refer the matter to the Medical Staff Health Committee for handling; (ii) if the particular health issue in question has been a matter under review by the Medical Staff Health Committee, but the Credentials Committee Chair, in consultation with the President, the Chief Medical Officer determines that the safety of patients or others is not in jeopardy, the Credentials Committee Chair shall refer the matter to the full Credentials Committee to review in accordance with Article Nineteen of these Bylaws; (iii) if the Credentials Committee Chair, in consultation with the President, the Chief Medical Officer a determines that the safety of patients

or others is in immediate jeopardy, the Credentials Committee Chair shall consider whether a precautionary restriction or suspension is appropriate under Article Nineteen of these Bylaws, in addition to referring the matter to the full Credentials Committee for review in accordance with Article Nineteen. If the Credentials Committee Chair decides to refer the matter to the Medical Staff Health Committee, he or she shall notify the Practitioner and the full Credentials Committee, and no further action need be taken by the Credentials Committee, except as provided by the Medical Staff Health Policy.

19.2.3 Options for Addressing Credible Concerns or Questions Raised in Investigation Request. As soon as possible after the Credentials Committee Chair's decision that a request is credible under Article Nineteen of these Bylaws or requires Credentials Committee review under Article Nineteen the Credentials Committee shall meet to determine whether to pursue any one or combination of the following courses of action:

(a) Attempt to resolve the matter informally, which informal resolution may include or consist of: (i) collegial intervention; (ii) a meeting with the Practitioner; (iii) an informal inquiry into the matter by the Credentials Committee or its designee, the results of which must be reported back to the full Credentials Committee; (iv) a voluntary agreement with the Practitioner; (v) issuance of a warning or letter of reprimand; (vi) the imposition of a monitoring, proctoring, consultation or review requirement that does not restrict the Practitioner's ability to exercise his or her Clinical Privileges; or (vii) development of a performance improvement plan with the Practitioner. If the attempt to informally resolve the matter is unsuccessful, or the actions taken do not satisfactorily resolve the matter as determined by the Credentials Committee, the Credentials Committee may pursue any other action described in this Article Nineteen, without the need for another request for Investigation.

(b) Initiate an Investigation of the matter, in accordance with the procedures described herein. For purposes of these Bylaws, the term "Investigation" shall be expressly defined to consist of those procedures described in Article Nineteen of these Bylaws and shall not include any other Professional Review Activity undertaken by the Hospital or the Medical Staff, including, but not limited to: a general or routine review of a particular Practitioner, a general or routine review of cases or other documentation of care provided by a particular Practitioner; ongoing professional practice evaluation activities; focused professional practice evaluation activities; any activities undertaken by the Medical Staff to evaluate a request for Investigation; or any other collegial peer review activity. An Investigation concludes at such point that a final report of the Investigation findings is completed and provided to the Medical Executive Committee.

(c) Impose a precautionary restriction or suspension pursuant to Article Nineteen of these Bylaws.

19.3 Investigations Procedures.

19.3.1 Designation of Investigating Body. If a decision is made pursuant to Article Nineteen of these Bylaws to initiate an Investigation, the Credentials Committee shall determine, in its sole discretion, whether the Investigation will be conducted by the

full Credentials Committee, a subcommittee of the Credentials Committee, or an ad hoc committee comprised of three members of the Active category of the Medical Staff. The members of any subcommittee or ad hoc committee shall be designated by the Credentials Committee Chair, in consultation with the Chief Medical Officer, the President and in compliance with applicable Conflict of Interest policies and procedures.

19.3.2 Resources Available to the Investigating Body. The investigating body shall have available to it the full resources of the Medical Staff and the Hospital to aid in its investigation and preparation of a report of its findings. Such resources shall include, without limitation, Hospital Representatives, legal counsel, and outside consultants and such assistance may include active participation in the Investigation process, including preparation of summary documents, draft reports, conducting interviews of witnesses and other information gathering.

19.4 Right of Investigating Body to Request Meeting With, Information From, or Physical or Psychological Evaluation of Practitioner. The investigating body may, in its sole discretion, request that the affected Practitioner meet with the investigating body or one of its members or its designees and/or provide information to the investigating body regarding the matter under Investigation. If the investigating body requests a meeting with the affected Practitioner, the Practitioner shall be informed of the general nature of the evidence supporting the Investigation and shall be invited to discuss, explain or refute such evidence. Any such meeting shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. The affected Practitioner shall not have the right to be represented by legal counsel before the investigating body nor to compel the investigating body to engage external consultation. A summary of such meeting shall be made by the investigating body and included with it report. The investigating body also may require a physical or psychological evaluation (or both) of the affected Practitioner by a physician or health care provider satisfactory to the body and require that the results of such evaluation(s) be made available to the body for consideration.

19.4.1 Investigation Findings Report.

(a) A report containing all relevant evidence that pertains to the question or concern giving rise to the Investigation and recommendations for action shall be prepared and provided to the appropriate Medical Executive Committee(s) by the Credentials Committee.

(b) If the Investigation is conducted by a subcommittee or an ad hoc committee, an initial report may be prepared by such body, but it must be submitted to the full Credentials Committee for review and consideration before being finalized. The Credentials Committee, in its sole discretion, shall have the right to accept, reject or modify any part of the report and to conduct further evaluation of the matter, as it deems necessary or appropriate.

(c) When considering an initial report prepared by a subcommittee or ad hoc committee, the Credentials Committee shall have available to it the full resources of the Medical Staff and the Hospital to aid in its investigation and preparation of a report of its findings. Such resources shall include, without limitation, Hospital Representatives, legal

counsel, and outside consultants and such assistance may include active participation in the Investigation process, including preparation of summary documents, draft reports, conducting interviews of witnesses and other information gathering.

(i) The Credentials Committee also may, in its sole discretion, request that the affected Practitioner meet with the Credentials Committee or one of its members or its designees and/or provide information regarding the matter under Investigation before finalizing the report. If the Credentials Committee requests a meeting with the affected Practitioner, the Practitioner shall be informed of the general nature of the evidence supporting the Investigation and shall be invited to discuss, explain or refute such evidence. Any such meeting shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. The affected Practitioner shall not have the right to be represented by legal counsel before the Credentials Committee nor to compel the investigating body to engage external consultation. A summary of such meeting shall be made by the Credentials Committee also shall be included with its report (if the Practitioner was previously interviewed by the investigating body, both summaries shall be included).

(ii) If the investigating body has not already requested it, the Credentials Committee may require a physical or psychological evaluation (or both) of the affected Practitioner by a physician or health care provider satisfactory to the Credentials Committee and require that the results of such evaluation(s) be made available to the Credentials Committee for consideration prior to finalizing its Investigation report.

19.4.2 Conclusion of the Investigation. The Investigation shall be concluded when the Credentials Committee finalizes the Investigation report.

19.5 Medical Executive Committee Review and Action.

19.5.1 Review of Investigation Report . At its next regular or special meeting after receipt of the Investigation Report, the Medical Executive Committee shall consider the report and the recommendations contained therein.

19.5.2 Requests for Additional Information and Inquiry; Available Resources. The Medical Executive Committee may, in its sole discretion, request that additional information be provided to it or fact-finding be conducted on its behalf before making a recommendation for action under Article Nineteen of these Bylaws. Such additional information requests or fact-finding inquiry may include any matter or issue determined by the Medical Executive Committee to be relevant to its process of evaluating the concern or question giving rise to the Investigation, including, without limitation, interviewing witnesses already interviewed by the investigating body or not interviewed by the investigating body, seeking the assistance of outside consultants and legal counsel, or any other type of external review process. The Medical Executive Committee shall have available to it the full resources of the Medical Staff and the Hospital to aid in its evaluation. Such resources shall include, without limitation, Hospital Representatives, legal counsel, and outside consultants and such assistance may include active participation in the Investigation process, including preparation of summary documents, draft reports, conducting interviews of witnesses and other information gathering.

19.5.3 Meeting with Affected Practitioner. The Medical Executive Committee shall provide the affected Practitioner the opportunity to meet with the full Medical Executive Committee prior to making a recommendation to the Governing Board regarding resolution of the concerns or questions giving rise to the Investigation. The Medical Executive Committee will have final approval of those present at this meeting. At this meeting, the affected Practitioner shall be invited to discuss, explain or refute the allegations supporting the Investigation for no more than 60 minutes. The Practitioner shall fully and honestly answer all questions posed by the Medical Executive Committee. Any meeting shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply.

19.5.4 Medical Executive Committee Action. After reviewing the Investigation Report, and any other additional information requested, the Medical Executive Committee(s) shall recommend a course of action to address the concerns or issues giving rise to the Investigation or any additional concerns or issues discovered during the Medical Executive Committee's review of same. Such recommendation may accept, modify or reject the recommendations of the Credentials Committee and may include any of the following:

(a) No corrective action.

(b) Informal action, which may include, but is not limited to, any of the options identified in Article Nineteen.

(c) A recommendation that one or more of the Practitioner's Clinical Privileges be revoked or suspended for a designated period or recommend mandatory consultation in specified cases for a designated period.

(d) A recommendation that the Practitioner's Medical Staff membership and all Clinical Privileges be revoked.

(e) Any other appropriate action.

19.5.5 Submit Recommendation to Governing Board. The Medical Executive Committee's recommendation for corrective action shall be forwarded in a written report to the Governing Board, which shall contain a statement of the grounds supporting the recommended action and the investigation report. The recommendation of the Medical Executive Committee shall not be effective until reviewed and approved by the Governing Board.

(a) If the Medical Executive Committee recommends any action described by Article Nineteen of these Bylaws, the Practitioner shall not be entitled to any procedural rights under Article Twenty of these Bylaws, and the recommendation shall be forwarded to the Governing Board for review in accordance with Article Nineteen of these Bylaws.

(b) If the Medical Executive Committee recommends any action described in Article Nineteen of these Bylaws, or any action taken under Article Six that would

be reportable to the National Practitioner Data Bank, the Practitioner shall be entitled to the procedural rights provided in Article Twenty of these Bylaws.

(c) Failure of the Practitioner to timely request a hearing, as set forth in Article Twenty of these Bylaws, shall be deemed a waiver of his or her right to a hearing and the recommendation of the Medical Executive Committee shall be forwarded to the Governing Board for final action pursuant to this Article Nineteen of these Bylaws.

19.6 Governing Board Review of Medical Executive Committee Recommendation That Does Not Entitle Practitioner to a Hearing. At its next regular or special meeting after the receipt of the Medical Executive Committee's recommendation, the Governing Board shall review such recommendation. The Governing Board may, in its sole discretion, accept, modify or reject the recommendations of the Medical Executive Committee.

19.6.1 Approval of Medical Executive Committee Recommended Action. If the Governing Board approves the recommended action of the Medical Executive Committee, and such recommended action would not entitle the Practitioner to procedural rights under Article Twenty of these Bylaws, it shall take effect immediately.

19.6.2 Rejection or Modification of Medical Executive Committee Recommended Action. In the event the Governing Board reviews the recommended action of the Medical Executive Committee, and then decides to modify that recommendation in any way or takes any action that was not specifically recommended by the Medical Executive Committee that entitles the Practitioner to a hearing, the Governing Board shall first refer the matter back to the Medical Executive Committee for reconsideration prior to taking any final action modifying the Medical Executive Committee action. The President and/or the Chief Medical Officer shall promptly notify the affected Practitioner that the matter has been referred by the Governing Board to the Medical Executive Committee for reconsideration. If upon reconsideration, the Medical Executive Committee recommends formal action that entitles the Practitioner to a hearing, the Practitioner shall be entitled to the procedural rights provided in Article Twenty of these Bylaws. If upon reconsideration, the Medical Executive Committee declines to modify its initial recommendation in the matter, the Governing Board may decide to modify the action of the Medical Executive Committee. To the extent that such modification would entitle the affected Practitioner to a hearing, the Practitioner shall be entitled to the procedural rights provided in Article Twenty of these Bylaws. In such cases, the proposed action shall not become final until after the Practitioner exhausts or waives his or her procedural rights under Article Twenty of these Bylaws and the Governing Board decides to make the action final.

19.7 Governing Board Action Upon Own Initiative. If the Governing Board determines that the Medical Staff has failed to act in an appropriate fashion in processing and recommending action on a request for corrective action or if no request for corrective action has been made, but the Governing Board determines that corrective action is warranted, the Governing Board may, after notifying the Medical Executive Committee in writing of its intent and designating an action date prior to which the Medical Executive Committee may still act, take action on its own initiative. If such action would entitle the Practitioner to a hearing, then: (a) such action shall not become final until after the Practitioner is afforded procedural rights

under Article Twenty of these Bylaws and the Governing Board decides to make the action final; and (b) the President and/or the Chief Medical Officer shall promptly inform the Practitioner in writing of such proposed action and of his or her procedural rights in accordance with Article Twenty of these Bylaws.

19.8 Precautionary Suspensions.

19.8.1 Criteria for Initiation of Precautionary Suspension. Whenever written documentation or other reliable information indicates that a Practitioner's conduct constitutes an immediate danger to the health and safety of patients, employees, Medical Staff Members, or other persons in the Hospital, , the Chief of Staff, the Chief Executive Officer, the Chief Medical Officer, the President or the Governing Board shall have the authority, as a precautionary measure, to suspend all or part of any Practitioner's Clinical Privileges. If time and circumstances permit, the persons or body with authority to invoke a precautionary suspension under this Article Nineteen shall consult with one another prior to imposing the suspension. In no event, however, shall any person or body vested with authority to impose a precautionary suspension under these Bylaws be deemed to lack the authority to act unilaterally if such consultation is not practical under the circumstances.

19.8.2 Notification and Procedural Rights. A Practitioner whose Clinical Privileges have been suspended on a precautionary basis shall be entitled to a hearing before the Medical Executive Committee. Written notice of the suspension, containing a brief statement of the grounds for suspension, shall be given immediately by the party imposing such suspension to the Practitioner, the Chief of Staff, the Chief Executive Officer, the Chief Medical Officer, the President, the Governing Board and the Credentials Committee. The Practitioner's written notice of the precautionary suspension shall state: (a) the reason for the action; (b) that the Practitioner has the right to request a hearing before the Medical Executive Committee to request that the precautionary suspension be lifted; (c) that any requested hearing will be commenced within 15 days; (d) that the deadline to request a hearing is three days from receipt of the notice; and (e) that any hearing request must be in writing.

19.8.3 Evaluation of Need for Investigation. Upon receipt of notice of the imposition of a precautionary suspension, the Credentials Committee shall immediately proceed, in accordance with Article Nineteen of these Bylaws to assess what action, if any, should be taken in response to the event(s) giving rise to the precautionary suspension. If the Credentials Committee decides to initiate an Investigation, the procedures in Article Nineteen shall be followed. If the Credentials Committee recommends that the precautionary suspension should be lifted, expunged or modified, this recommendation should be forwarded to the Medical Executive Committee for action.

19.8.4 Hearing before the Medical Executive Committee. The Medical Executive Committee shall provide the affected Practitioner the opportunity to meet with the Medical Executive Committee. At this meeting, the affected Practitioner shall be invited to discuss, explain or refute the allegations supporting the precautionary suspension and may request lifting or modification of the suspension. The Practitioner shall fully and honestly answer all questions posed by the Medical Executive Committee. Any meeting

shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. The affected Practitioner shall not have the right to be represented by legal counsel before the Medical Executive Committee.

19.8.5 Medical Executive Committee Action. After hearing the Practitioner's presentation and reviewing any available information, the Medical Executive Committee(s) shall recommend whether to lift, expunge, stay or modify the precautionary suspension. If the Medical Executive Committee recommends that the precautionary suspension should be lifted, expunged or modified, the Medical Executive Committee shall forward such recommendation to the Governing Board for expedited approval.

19.8.6 Patient Assignment. In the event of precautionary suspension, the Practitioner's patients then hospitalized shall be assigned to the Chief of Staff. The Chief of Staff will assume responsibility for the patient's care or he or she may designate a substitute Practitioner. The substitute Practitioner shall have the right to refuse to accept such patient assignment. The wishes of the patient and the attending Practitioner shall be considered, where feasible, in choosing a substitute Practitioner.

ARTICLE TWENTY

HEARING AND APPELLATE REVIEW

20.1 Grounds for a Hearing.

20.1.1 Actions That Entitle the Affected Practitioner To a Hearing. Only the following actions shall entitle the affected Practitioner to a hearing:

(a) Denial of initial Medical Staff appointment.

(b) Denial of requested advancement in Medical Staff category when such denial affects the exercise of Clinical Privileges.

(c) Denial of Medical Staff reappointment.

(d) Revocation of Medical Staff appointment.

(e) Denial of requested initial or increased Clinical Privileges.

(f) Decrease or suspension of Clinical Privileges, except for administrative suspensions due to failure to attend Medical Staff meetings or failure to complete medical records, which suspensions shall be subject to the provisions set forth in Article Twenty-one of these Bylaws.

(g) Imposition of a mandatory consultation requirement (except as may be required during provisional appointment in accordance with these Bylaws).

(h) Denial of reinstatement after a leave of absence.

(i) Subject to Article Twenty, total or partial termination or reduction of Medical Staff membership or Clinical Privileges of a current Medical Staff member because of the Hospital's decision to enter an exclusive contract or close a clinical area when such action is taken with respect to a clinical area that was not subject to an exclusive contract or closed prior to such action.

20.1.2 Actions That Do Not Entitle the Affected Practitioner to a Hearing. The following actions do not entitle the affected Practitioner to the hearing procedures set forth in this Article Twenty:

(a) The initiation of an Investigation.

(b) The appointment of an ad hoc committee to conduct an Investigation.

(c) The restriction of Clinical Privileges, other than a precautionary suspension, for 30 days or less including, without limitation, restriction of Clinical Privileges during any applicable cure period under Article Twenty-one of these Bylaws, due to failure to attend Medical Staff meetings under the Bylaws or due to failure to complete medical records in accordance with the Bylaws and the Rules and Regulations.

(d) Transmittal of any preliminary report of the ad hoc committee to the Medical Executive Committee.

(e) The rejection of an application for appointment to the Medical Staff or an increase in Clinical Privileges because of an existing exclusive contract and/or closed panel.

(f) Any voluntary relinquishment of Medical Staff membership or Clinical Privileges contractually agreed to by the Practitioner as part of an exclusive agreement, unless the Practitioner is under Investigation by the Hospital relating to possible incompetence or improper professional conduct, or such resignation is given in return for not conducting such an Investigation or other corrective action proceeding.

(g) Any automatic relinquishment of Medical Staff membership or Clinical Privileges pursuant to Article Twenty-one of these Bylaws, including without limitation automatic relinquishment due to Practitioner's failure to appear before an ad hoc committee or Medical Staff committee or representative thereof or to submit a complete application for reappointment prior to expiration of the Practitioner's appointment period.

(h) The rejection of a pre-application.

(i) The denial or revocation of temporary or emergency Clinical Privileges.

(j) Imposition of a monitoring or consultation requirement during a provisional period.

(k) Intensive review without direct supervision or requirement for consultation.

(l) A letter of warning, admonition or reprimand.

(m) Requirement for corrective counseling.

(n) Requirement for training or education requirements.

(o) Change in Medical Staff category due to failure to meet qualifications or requirements for the Medical Staff category in question.

20.1.3 Notice of Proposed Adverse Action. When a recommendation is made or an action initiated which, according to these Bylaws, entitles a Practitioner to a hearing, the President, and the Chief Medical Officer shall promptly notify the affected Practitioner in writing. The written notice shall state:

(a) That an action has been proposed against the Practitioner.

(b) The reasons for the proposed action, including whether the proposed action is based substantially on economic factors.

(c) That the Practitioner has the right to request a hearing.

(d) The deadline to request a hearing.

(e) A copy of Article Twenty that outlines the Practitioner's procedural rights pursuant to these Bylaws.

20.1.4 Deadline for Requesting a Hearing. To be entitled to a hearing, the affected Practitioner must submit a written request for a hearing to the President and/or the Chief Medical Officer within 30 days from the date of the affected Practitioner's receipt of the notice provided pursuant to Article Twenty above of these Bylaws. If the affected Practitioner fails to timely submit the written request for a hearing to the President and/or the Chief Medical Officer, the affected Practitioner will be deemed to have waived the right to a hearing and to have accepted the recommended action, which shall become effective immediately upon final decision by the Governing Board. To the extent that Article Twenty fails to adequately specify procedures for affording a Practitioner due process, the Governing Board may, with input of the Medical Executive Committee, establish additional procedures to permit the effective resolution of such matter.

20.2 Scheduling the Hearing.

20.2.1 Date of Hearing. Upon receipt of a written request from the affected Practitioner for a hearing, the President and/or the Chief Medical Officer shall schedule the hearing as soon as practicable, but no sooner than 30 days and not more than 90 days after the date the notice of the hearing will be provided to the Practitioner under Article Twenty

of these Bylaws, unless an earlier hearing date has been specifically agreed to in writing by the parties.

20.2.2 Notice to Practitioner. Upon scheduling the hearing, the President and/or the Chief Medical Officer shall promptly give written notice to the affected Practitioner stating the place, time and date of the hearing along with a list of the documents expected to be presented and the witnesses (if any) expected to testify at the hearing on behalf of the Medical Staff or Governing Body. The notice also shall state that:

(a) The Practitioner has 10 days from the date of the notice to notify the President and/or the Chief Medical Officer of representation by counsel.

(b) The Practitioner has 14 days from the date of the notice to provide to the President and/or the Chief Medical Officer a list of the documents expected to be presented and the witnesses (if any) expected to testify at the hearing on behalf of the Practitioner.

(c) The parties shall simultaneously exchange copies of all documents listed in the list provided to the other party, pursuant to this Article, not later than 14 days before the hearing date; however, if the Hospital will be providing any confidential documents to the Practitioner, the Practitioner must sign a confidentiality agreement acceptable to the Hospital.

20.2.3 Amending or Supplementing Information. The information provided by the Hospital, including the list of documents, may be supplemented or amended at any time, even during the hearing. The witness list of either party may be supplemented or amended at any time during the course of the hearing.

20.3 Appointment of Hearing Panel. Within 15 days of receipt of a request for hearing, the President, the Chief Medical Officer and the Chief of Staff shall appoint a hearing panel comprised of three (3) members of the Medical Staff, no more than one (1) of whom may be a member of the Contract Staff category of Medical Staff. Knowledge of the matter involved shall not preclude a Medical Staff member from serving on the hearing committee, but a Medical Staff member who was directly involved in making the adverse recommendation shall not be eligible to serve as a hearing panel member. In the event it is not practical to appoint a hearing panel from the Medical Staff, the President, the Chief Medical Officer and the Chief of Staff may appoint Physicians with a good reputation outside of the Medical Staff. Once selected, the affected Practitioner shall be given written notice of the hearing panel members selected and shall have a one-time right to request one member of the panel be removed for any reason, and a new member appointed in accordance with this Article. This one-time right must be exercised, in writing, within 48 hours of the date of the notice. The affected Practitioner shall have no right or opportunity to challenge the replacement member appointed in accordance with this Article. A simple majority of the members of the hearing panel shall constitute a quorum. Hearing panel members who are not present at one or more sessions of the hearing may vote on all decisions made by the hearing panel if they review the transcript of minutes and exhibits of the session(s) they did not attend.

20.4 Hearing Officer. The President and/or the Chief Medical Officer, in consultation with the Chief of Staff, shall appoint a hearing officer. A hearing officer need not be a physician or a Medical Staff member. If the hearing officer is appointed, the hearing officer may participate in the private deliberations of the hearing panel, but shall not be entitled to vote on its recommendation.

20.5 Hearing Procedures.

20.5.1 Representation. The President and/or the Chief Medical Office may appoint a Medical Staff member, attorney or other person to represent the position of the Medical Staff, or the position of the Governing Board if it unilaterally initiated the adverse action, at the hearing. If the Practitioner is represented by an attorney at the hearing, the Medical Staff, or the Governing Board if it unilaterally initiated the adverse action, shall also be represented by an attorney at the hearing.

20.5.2 Failure to Appear at Hearing. Failure, without good cause, of the affected Practitioner to appear and proceed at the hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions, which recommendations or actions shall become final and effective immediately upon ratification by the Governing Board.

20.5.3 Prehearing Matters. The hearing officer may confer with the parties and/or their attorneys in advance of the hearing in order to facilitate the defining and narrowing of issues, the identification of evidence, the identification of witnesses and a general identification of expected evidence. At such prehearing conference, the hearing officer may establish reasonable procedures for the conduct of the hearing. The hearing officer may require the parties to participate in a prehearing conference, either in person or by telephone.

20.5.4 Time Frames for Conduct of the Hearing. The hearing officer shall establish reasonable time frames for the presentation of evidence for each side and for conduct of the hearing. Unless extraordinary circumstances exist, as determined in the sole discretion of the hearing officer, each party shall be allotted six hours to present its evidence, including without limitation, direct and cross-examination of witnesses and presentation of any rebuttal testimony. Any time limits set forth in this Article Twenty or established by the hearing officer may not be modified thereafter without the written consent of both parties.

20.5.5 Rights of the Parties. At the hearing, each party shall have the following rights:

(a) To call and examine witnesses.

(b) To introduce exhibits.

(c) To cross-examine witnesses and to rebut any evidence (if the affected Practitioner chooses not to testify on his or her own behalf, the affected Practitioner may be called and examined as if under cross-examination).

(d) To be represented by counsel.

20.5.6 Admission of Evidence. The hearing shall not be conducted according to the rules of law related to the examination of witnesses or the presentation of evidence. Any evidence that is directly relevant to the decision recommended by the Medical Executive Committee and/or the Governing Board, if applicable, shall be admitted. Each party shall have the right to submit a written statement, which shall be filed within the timeframe set by the hearing officer, but no later than 15 days after the record of the hearing is prepared. The hearing panel may interrogate the witnesses, call additional witnesses or request documentary evidence, if it deems it appropriate. The hearing officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of this state. The parties shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority.

20.5.7 Burden of Proof. The Medical Executive Committee, or the Governing Board if it initiated the adverse action, shall first come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the Practitioner. The hearing panel shall recommend in favor of the Medical Staff unless it finds that the Practitioner has proven that the recommendation of the Medical Executive Committee and/or proposed action of the Governing Board is arbitrary, capricious or not sustained by substantial evidence.

20.5.8 Record of Hearing. A record of the hearing shall be maintained by a reporter present to make a record or a recording of the proceedings. The cost of the reporter shall be borne by the Hospital. Upon the request of the affected Practitioner, Hospital shall provide a copy of the transcript of the proceedings, provided that the Practitioner pays the reasonable cost of preparing the copy.

20.5.9 Basis of Decision. The decision of the hearing panel shall be based on the evidence produced at the hearing. This evidence may consist of:

(a) Oral testimony of witnesses.

(b) Memorandum of points and authorities presented in connection with the hearing.

(c) Any information regarding the Practitioner, so long as that information was admitted at the hearing and the Practitioner had the opportunity to comment on and, by evidence, refute it.

(d) Any and all applications, references and accompanying documents.

(e) Other documented evidence, including medical records.

(f) Any other evidence that has been admitted.

20.5.10 Hearing Report. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. Within five business days after the final adjournment of the hearing and the submission of any post-hearing memoranda, the hearing panel shall conduct its deliberations outside the presence of any other person (except the hearing officer, if one is appointed) and shall render a recommendation on the matter in a written report. The report shall be provided to the President and/or the Chief Medical Officer for distribution and shall set forth the recommendation of the hearing panel, including a concise statement of the basis for the recommendation. As soon as such report is received, the President and/or the Chief Medical Officer shall send a copy to the affected Practitioner and the Medical Executive Committee.

20.5.11 Medical Executive Committee Action on Hearing Report. The Medical Executive Committee shall review the hearing panel's report and may, but is not required to, modify or revoke its original recommended action. The Medical Executive Committee shall then forward the hearing report, together with any additional recommendations it may have, to the Governing Board for final action.

20.5.12 Governing Board Action. The Governing Board shall take action on the matter within 10 business days of its receipt of the recommendation of the Medical Executive Committee and the hearing report. If the Governing Board initially determines that an adverse action as described in Article Twenty of these Bylaws is warranted with respect to the affected Practitioner, it shall defer final action on the matter, and direct the President and/or the Chief Medical Officer to give the affected Practitioner written notice of such initial determination, including a statement of the basis for the initial determination, and afford the affected Practitioner with the appeal procedures set forth in Article Twenty of these Bylaws. Any action taken by the Governing Board that does not constitute an adverse action pursuant to Article Twenty of these Bylaws shall take effect immediately and the President and/or the Chief Medical Officer shall immediately notify the Medical Executive Committee and the affected Practitioner of the action.

20.6 Appeal.

20.6.1 Basis for Appeal. If, after considering the decision of the hearing panel and the Medical Executive Committee recommendation, the Governing Board decides to take any action set forth under Article Twenty of these Bylaws, then, and only then, shall the Practitioner be entitled to an appeal to the Governing Board under this Article Twenty of these Bylaws. If the Practitioner does not request appellate review within five days after receiving notice of the proposed adverse action of the Governing Board that entitles the Practitioner to an appeal, the Practitioner shall be deemed to have waived all rights to an appeal and the Governing Board shall take final action on the matter.

20.6.2 Request for Appeal. The Practitioner's request shall be in writing and delivered to the Chief Medical Officer either in person, or by certified or registered mail within five days after receiving notice of the Governing Board's proposed adverse action. The request shall be accompanied by a written appeal setting forth the Practitioner's objections and exceptions to the decision of the Governing Board and the recommendation of the Medical Executive Committee and the hearing panel.

20.6.3 Grounds for Appeal. The grounds for appeal shall be limited to the following:

(a) An allegation that there exists a substantial failure on the part of the hearing panel, the Medical Executive Committee or the Governing Board to comply with these Bylaws in the conduct of the hearings or in their decision, so as to deny the Practitioner due process or a fair hearing; or

(b) An allegation that the proposed adverse action is arbitrary, capricious or not supported by credible evidence.

20.6.4 Scheduling the Appellate Review. The Governing Board shall, within 10 business days after receipt of a request for appellate review, schedule and arrange for an appellate review. The affected Practitioner shall be given notice of the time, date and place of the appellate review. The date of the appellate review shall be not less than 10 business days, nor more than 30 days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from a Practitioner who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than 14 business days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the chair of the Governing Board for good cause.

20.6.5 Appellate Review Panel. The Governing Board shall appoint a review panel composed of not less than three persons, either members of the Governing Board or others, to consider the record on which the recommendation was made. The chair of the Governing Board shall appoint an appellate review panel chair.

20.6.6 Appellate Review Procedures.

(a) Prehearing Matters. The appellate review panel chair may confer with the parties and/or their attorneys in advance of the appellate review in order to facilitate the defining and narrowing of issues. At such prehearing conference, the appellate review chair may establish reasonable procedures for the conduct of the appellate review. The appellate review chair may require the parties to participate in a prehearing conference, either in person or by telephone.

(b) Submission of Evidence. The review panel may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided for in the hearing procedures set forth in Article Twenty of these Bylaws. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that any opportunity to admit it at the hearing was denied, and then only at the discretion of the review panel. Each party shall have the right to present a written statement in support of its position on appeal, and in its sole discretion, the review panel may allow each party or its representative to appear personally and make oral argument.

(c) Review Panel Recommendation. The review panel shall recommend final action to the Governing Board. The Governing Board may affirm, modify or reverse the recommendation of the review panel.

(d) Final Decision of the Governing Board. Within 10 business days after receipt of the review panel's recommendation, the Governing Board shall render a final decision in writing, including a statement of the basis for the final decision, and the President and/or the Chief Medical Officer shall deliver copies to the affected Practitioner, the Medical Executive Committee, and the Chief of Staff. If such final decision is based substantially on economic factors, such written decision shall be provided at least 15 days prior to implementation and the President and/or the Chief Medical Officer shall notify the Hospital Licensing Board as required by law. The final decision of the Governing Board following the appeal shall be effective immediately and shall not be subject to further review. After the Governing Board renders its final decision in the matter, Chief Medical Officer shall report adverse Professional Review Actions in accordance with applicable law.

(e) Right to One Hearing and One Appeal Only. A Practitioner is entitled to only one hearing and one appeal in connection with any single matter that may be the subject of a hearing and appeal, regardless of whether the action is taken by the Medical Executive Committee or the Governing Board, unilaterally or by a combination of their acts. In the event that the Governing Board ultimately denies initial Medical Staff appointment or reappointment to a Practitioner, or moves to revoke or terminate the Medical Staff appointment of a current Practitioner, that Practitioner may not reapply for Medical Staff appointment at this Hospital, unless the Governing Board provides otherwise in its final decision.

20.7 Special Procedures Applicable to Medical Staff Members Affected By Exclusive Contracts. If a Hospital exercises its option to enter into an exclusive contract in a clinical service area or with respect to any part of the Hospital that is not subject to an exclusive arrangement and such contract will result in the total or partial termination or reduction of the Medical Staff membership or Clinical Privileges of a current Medical Staff member or members who are not already members of the contract staff, the Hospital shall provide the affected Medical Staff member(s) 60 days' prior written notice of such action. An affected Medical Staff member desiring a hearing under this Article Twenty must request the hearing within 14 days after the date he or she is so notified. The requested hearing shall be commenced and completed (with a report and recommendation to the affected Medical Staff member, the Governing Board, and Medical Staff) within 30 days after the date of the Medical Staff member's request. Notwithstanding the foregoing, in no event shall this provision be interpreted to provide procedural rights to any member of the contract staff or any other Practitioner who enters or who has entered into an exclusive contract with the Hospital and whose Medical Staff membership and Clinical Privileges have been modified or terminated pursuant to such contract.

ARTICLE TWENTY-ONE

SPECIAL DUE PROCESS PROVISIONS FOR AUTOMATIC RELINQUISHMENT AND ADMINISTRATIVE SUSPENSIONS

21.1 Automatic Voluntary Relinquishment.

21.1.1 Grounds for Automatic Voluntary Relinquishment. A Practitioner shall automatically be deemed to have voluntarily relinquished his or her Medical Staff membership, as well as all Clinical Privileges, upon the occurrence of any of the events

listed below. The Hospital shall provide written notice of the automatic relinquishment, which shall be effective unless subject to a cure period as determined by the Hospital in its discretion or in accordance with Article Nineteen.

(a) Revocation of any license to practice medicine, dentistry or podiatry, as applicable, registration with the federal Drug Enforcement Administration or any state controlled substance license or nonrenewal of Practitioner's Illinois license to practice medicine, dentistry or podiatry, as applicable, registration with the federal Drug Enforcement Administration or Illinois Controlled Substance License.

(b) Failure to report any event required to be reported immediately to the President and/or the Chief Medical Officer under Article Three of these Bylaws.

(c) Failure to appear at a meeting of the Medical Staff in order to discuss proposed corrective action, if requested to attend and properly notified.

(d) Exclusion from any federally funded health care program, including, without limitation, Medicare or Medicaid.

(e) Conviction of any felony or misdemeanor that involves controlled substances, health care, violence or moral turpitude.

(f) Failure to comply with the terms of a voluntary agreement with the Medical Staff and/or Hospital.

(g) Failure to be truthful and/or make full disclosure in written or oral communications to Hospital, the Medical Staff or any Medical Staff committee or Professional Review Body.

(h) Failure to produce information requested as part of peer review process or Investigation.

(i) Failure to sign an authorization to obtain and/or release to obtain information from a Third Party as required by the Bylaws.

(j) Failure to maintain professional liability insurance or tail coverage as required by these Bylaws or Hospital.

(k) Failure to produce information requested by the Credentials Committee or the Medical Executive Committee for any credentialing purpose, including, but not limited to, information needed to evaluate a Practitioner, conduct an Investigation, or to otherwise complete an appointment or reappointment application.

(l) Failure to obtain specified immunizations or infectious disease testing as established by local, state or federal law or the Medical Staff.

(m) Failure to maintain and complete medical records as required by the Bylaws and the Rules and Regulations after being suspended for a period of fifteen days

(n) Failure to advance from Associate Staff to Active Staff or another Medical Staff category after completing a 36-month term of appointment and reappointment.

(o) Failure to do any of the following with respect to reinstatement:

(i) request reinstatement after the expiration of 24 months;

(ii) respond to a Credentials Committee request for information in connection with the evaluation of a reinstatement request; or

(iii) Satisfy conditions of reinstatement after a leave of absence.

21.1.2 Automatic Relinquishment Events Subject to Cure Period. A Practitioner shall automatically be deemed to have voluntarily relinquished his or her Medical Staff membership, as well as all Clinical Privileges, if after receipt of written notice and an opportunity to cure, which cure period may not exceed 30 days, Practitioner fails to cure any of the events listed below. During the cure period Practitioner is deemed to have voluntarily agreed not to exercise Clinical Privileges and, therefore, may not admit or treat patients at Hospital.

(a) Nonrenewal of Illinois license to practice medicine, dentistry or podiatry, as applicable, registration with the federal Drug Enforcement Administration or Illinois Controlled Substance License.

(b) Failure to produce information requested as part of peer review process or Investigation.

(c) Failure to sign an authorization to obtain and/or release to obtain information from a Third Party as required by the Bylaws.

(d) Failure to maintain professional liability insurance or tail coverage as required by these Bylaws or Hospital.

(e) Failure to produce information to conclude or extend a provisional appointment period or to complete a reappointment application.

(f) Failure to obtain proper immunizations or infectious disease testing as required these Bylaws or Hospital policy as outlined in Article three.

(g) Failure to maintain and complete medical records as required by the Bylaws and the Rules and Regulations after being suspended for a period of fifteen days.

(h) Failure to maintain Board Certification requirements

(i) Failure to advance from Associate Staff to Active Staff or another Medical Staff category after completing a 36-month term of appointment.

(j) Failure to do any of the following with respect to reinstatement:

(i) Request reinstatement after the expiration of 24 months;

(ii) Respond to a Credentials Committee request for information in connection with the evaluation of a reinstatement request; or

(iii) Satisfy conditions of reinstatement after a leave of absence.

21.2 Special Procedures for Automatic Relinquishment, Suspension for Failure to Attend Meetings and Suspension for Failure to Complete Medical Records.

21.2.1 Right to Request Meeting with Medical Executive Committee. Practitioner shall have 24 hours from receipt of notice of any of the following events to request a meeting with the Medical Executive Committee:

(a) Automatic relinquishment, if such relinquishment is not subject to cure;

(b) Failure to cure a condition resulting in automatic relinquishment within the specified timeframe for cure;

(c) Suspension for failure to attend Medical Staff meetings; or

(d) Suspension for failure to complete medical records.

21.2.2 Medical Executive Committee Meeting. If requested by the Practitioner, the Medical Executive Committee shall convene a meeting as soon as possible, or within seven days. The Medical Executive Committee meeting shall be deemed a "fair hearing" to the extent a hearing is required under the circumstances by the Illinois Hospital Licensing Act. At this meeting, the Medical Executive Committee may consider only whether:

(a) In the case of automatic relinquishment, grounds for the automatic relinquishment exist, or, if applicable or appropriate given the circumstances, the cure period should be extended.

(b) In the case of suspension for failure to attend Medical Staff meetings, the Practitioner failed to attend meetings.

(c) In the case of suspension for failure to complete medical records, the Practitioner has not completed his or her records within time frames specified in the Rules and Regulations.

After this meeting, the automatic relinquishment, or suspension, shall be effective immediately unless the Medical Executive Committee decides to extend the cure period or finds that grounds for automatic relinquishment or suspension do not exist. In no event may the Medical Executive Committee extend a cure period beyond 30 days.

21.3 Interpretation. Automatic relinquishment or suspension for failure to complete medical records or attend Medical Staff meetings is a voluntary action by the affected Practitioner and shall not be deemed to be a Professional Review Action or an "adverse decision" under the Illinois Hospital Licensing Act. A Practitioner whose Medical Staff membership and Clinical Privileges are automatically relinquished or suspended shall not be entitled to any due process, other than that specified in this Article Twenty.

APPENDIX A

KISH*HEALTH* SYSTEM

CODE OF CONDUCT

POLICY

It is the policy of Kish*Health* System that all Employees, Board Members, Medical Staff Members, Volunteers and Outside Parties will conduct themselves in compliance with the Kish*Health* System Compliance Plan, Code of Conduct, policies and procedures, and applicable local, state, and federal laws and regulations.

INTRODUCTION

This Code of Conduct has been adopted by the Board to provide standards by which Employees, Board Members, Medical Staff Members, Volunteers and Outside Parties of all the legal Entities within the Kish*Health* System will conduct themselves in order to protect and promote organization-wide integrity and enhance the ability to achieve our mission. The Code of Conduct contains the principles that serve as the basis for KHS's compliance policies and procedures. The Code of Conduct shall be distributed periodically to all Employees, Board Members, Medical Staff Members, Volunteers and Outside Parties of KHS. This Code of Conduct is complemented by KHS policies and procedures currently in effect that focus on promoting KHS compliance and have been implemented to address compliance risk areas.

LEADERSHIP RESPONSIBILITIES

While all Employees, Board Members, Medical Staff Members, Volunteers and Outside Parties of KHS are required to follow the Code of Conduct, KHS expects its leaders to set an example and to be, in every respect, a model for all. Our leaders must ensure that those on their team have sufficient information to comply with the laws, regulations and policies that govern health care operations in Illinois. Our leaders must help to create an atmosphere within KHS that promotes the highest standards of compliance. This atmosphere must encourage everyone in our organization to maintain open lines of communication to facilitate reporting of compliance concerns when they arise.

PRINCIPLES

Principle 1: Legal Compliance

KHS will strive to ensure that all activity by or on behalf of the organization is in compliance with applicable local, state, and federal laws. Employees, Board Members, Medical Staff Members, Volunteers and Outside Parties are responsible for performing their duties in compliance with all applicable local, state, and federal laws. If there is a doubt as to the legality of any action, KHS shall seek advice from its legal counsel before taking action. Employees, Board Members, Medical Staff Members, Volunteers and Outside Parties are responsible for

seeking advice from their supervisor or manager when there are questions about the legality of any action.

Principle 2: Business Ethics

In furtherance of KHS's commitment to the highest standards of business ethics and integrity, Employees, Board Members, Medical Staff Members, Volunteers and Outside Parties will accurately and honestly represent KHS and will not engage in any activity or scheme intended to defraud anyone of money, property or services. This principle includes screening of new Employees, Board Members, Medical Staff Members and Volunteers to ensure compliance to participation in the Centers for Medicare and Medicaid Programs, and furthermore, by screening against the Excluded Provider Registry and the Government Sanctions List, as well as, appropriate background checks in accordance with state and federal professional licensing boards.

Principle 3: Patient Care

KHS expects that the safety of patients and quality of care provided to patients will be a primary consideration behind decisions made and actions taken when providing such care. Employees, Board Members, Medical Staff Members, Volunteers and Outside Parties involved in the delivery of health care services will at all times follow the code of ethics and standards of practice of their respective professional organizations when providing patient care services, as well as KHS policies and procedures. At no time shall an Employee, Board Member, Medical Staff Member, Volunteer or Outside Party discriminate against a patient because of race, religion or culture, and at all times respect a patient's rights and advanced directives. If there is a question about whether quality, patient safety or patient rights are being fully met, Employees, Board Members, Medical Staff Members, Volunteers and Outside Parties are expected to bring their concern to their supervisor, manager, or the Compliance Officer without the fear or threat of retaliation or retribution.

Principle 4: Confidentiality

KHS Employees, Board Members, Medical Staff Members, Volunteers and Outside Parties shall respect the dignity of each individual, including their right to privacy/confidentiality. Confidential information includes, but is not limited to, patient information, personnel information, member information, proprietary (e.g. business, financial, planning) information, current and potential client information, and third party information. Any of this information in the possession of Kish*Health* System, or for which Kish*Health* System is responsible, regardless of where it originated, is confidential. Confidential information may be in the format of verbal, written or electronic communication.

Principle 5: Conflicts of Interest

Directors, officers, management, Medical Staff, Volunteers, committee members and key Employees owe a duty of undivided and unqualified loyalty to the organization. In accordance with the Conflicts of Interest policy, persons holding such positions may not use their positions to profit personally or to assist others in profiting in any way at the expense of the organization.

Principle 6: Business Relationships

KHS, together with each of its affiliates and subsidiaries requires compliance with the requirements of state and federal laws that prohibit the submission of false or improper claims in connection with state and federal health care programs, including Medicare and Medicaid. Every KHS Employee, Board Member, Medical Staff Member and Volunteer, as well as employees of KHS's contractors and agents (as defined below), must abide by this Code of Conduct.

Business transactions with vendors, contractors and other third parties shall be transacted without improper kickbacks, inducements, gifts, favors or other things of value provided or received that improperly influence or gain assistance in a transaction. KHS's Compliance Program provides specific details regarding internal policies, procedures and individuals' responsibilities to prevent and detect fraud, waste and abuse. Additionally, KHS's Compliance Program provides for rigorous internal investigations and prompt resolution of alleged violations. Depending on the nature of the violation, investigations of integrity or compliance issues may be performed by the Compliance Officer, Human Resources, legal counsel and/or other appropriate staff or consultants.

KHS, through the KHS Compliance Program and training programs for new and current employees, educates and trains all KHS Employees about the federal False Claims Act, Illinois False Claims Act, the Illinois insurance false claims acts, the federal Program Fraud Civil Remedies Act of 1986 and all whistleblower protections available under these laws. In each contract between KHS and an entity or person who supplies goods or services to KHS (collectively, "**Agents and Contractors**"), the Agent or Contractor is required to demonstrate that its employees also are educated and trained on federal False Claims Act, Illinois False Claims Act, the Illinois insurance false claims acts, the federal Program Fraud Civil Remedies Act of 1986 and all whistleblower protections available under these laws, either by agreeing to provide this Policy and KHS's training program/materials to its employees, or by demonstrating to the satisfaction of the KHS's Compliance Officer that it has equivalent policies and training programs in place.

Principle 7: Protection of Assets

All Employees, Board Members, Medical Staff Members, Volunteers and Outside Parties will strive to preserve and protect KHS's assets by making prudent and effective use of KHS resources and properly and accurately reporting its financial condition.

Principle 8: Obligation to Report

Employees, Board Members, Medical Staff Members, Volunteers and Outside Parties have an obligation to report actual or suspected violations of the Plan, Code of Conduct, KHS policies and procedures, or applicable state and federal laws to a supervisor, manager, the KHS Corporate Compliance Officer, a member of the KHS management team, or through EthicsPoint website or telephone hotline. Any Employee, Board Member, Medical Staff Member, Volunteer and Outside Party who, in good faith, reports a compliance concern is protected by KHS's non-retaliation policy.

ADMINISTRATION AND APPLICATION OF THIS CODE OF CONDUCT

KHS expects each person to whom this Code of Conduct applies to abide by the principles set forth herein and to conduct the business and affairs of KHS in a manner consistent with these principles.

Nothing in this Code of Conduct is intended to nor shall be construed as providing any additional employment or contract rights to our Employees or others.

While KHS will generally attempt to communicate changes concurrent with or prior to the implementation of any changes, KHS reserves the right to modify, amend or alter the Code of Conduct without notice.