301 BECKER AVENUE SW
WILLMAR, MINNESOTA

MEDICAL STAFF BYLAWS

Adopted by Medical Staff: 06/06/2017

Approved by Board of Directors: 06/21/2017

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Preamble

These bylaws are adopted in order to provide for the organization of the medical staff of Rice Memorial Hospital in accord with Hospital Bylaws Article VII and to provide a framework of medical staff governance in order to permit the medical staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These bylaws provide the professional and legal structure for medical staff operations, organized medical staff relations with the Board of Directors, and relations with applicants to and members of the medical staff.

Definitions

1. ADMINISTRATOR means the person appointed by the Board of Directors to serve as the Chief Executive Officer of the hospital.

2. ALLIED HEALTH STAFF means the licensed patient care providers other than physicians, oral surgeons, or podiatrists (including, but not limited to, Advanced Practice Registered Nurses or physician assistants) who are recognized under the Bylaws for purposes of providing patient care services in the Hospital.

3. AUTHORIZED REPRESENTATIVE or HOSPITAL'S AUTHORIZED REPRESENTATIVE means the individual designated by the hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws. Unless otherwise specified by the Medical Executive Committee, the individual will be the Chief Medical Officer of the hospital, or designee.

4. BOARD OF DIRECTORS means the governing body of the hospital.

5. CHIEF OF STAFF means the chief officer of the medical staff elected by members of the medical staff.

6. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to medical staff members to provide patient care and includes unrestricted access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.

7. CORRECTIVE ACTION means the termination of medical staff membership or a restriction, reduction, modification or termination of clinical privileges for reasons of clinical incompetence or unprofessional conduct.

8. HOSPITAL means Rice Memorial Hospital.

9. IN GOOD STANDING means, at the time of the assessment of standing, his/her membership and/or privileges are not involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reasons (excluding leaves of absence).

10. INPATIENT means patients admitted to inpatient level of care requiring complex medical care with the expectation of the need for two or more midnights of medically necessary hospital care.

11. INVESTIGATION means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the medical staff.

12. MEDICAL EXECUTIVE COMMITTEE means the executive committee of the medical staff which shall constitute the governing body of the medical staff as described in these bylaws.

13. MEDICAL STAFF or STAFF means those physicians (MD or DO or their equivalent as defined in Article 2.2-2A), oral surgeons (as defined in Article 2.2-2B), or podiatrists (as defined in Article 2.2.-2C) who have been granted recognition as members of the medical staff pursuant to the terms of these bylaws.

14. MEDICAL STAFF YEAR means the period from 01 January to 31 December.

15. MEMBER means, unless otherwise expressly limited, any physician (MD or DO or their equivalent as defined in Article 2.2-2A), oral surgeon (as defined in Article 2.2-2B), or podiatrist (as defined in Article 2.2.-2C) holding a current license to practice within the scope of his or her license who is a member of the medical staff.

16. ORAL SURGEON means anyone licensed by the Minnesota Board of Dentistry that has completed a postgraduate residency in Oral and Maxillofacial Surgery.

17. PHYSICIAN means an individual with an MD or DO degree or their equivalent. "Their equivalent" shall mean any degree recognized by the licensing boards in the State of Minnesota to practice medicine and surgery.

18. PODIATRIST means anyone licensed by the Minnesota Board of Podiatric Medicine that has completed a podiatric residency approved by the Council on Podiatric Medical Education (CPME) or another recognized accrediting body accepted by the CPME.

19. REVIEW ACTION means action when it is taken or made in the conduct of professional review activity: which is based on the competence or professional conduct of an individual physician or Allied Health Staff member (whose conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician or Allied Health Staff member.

Article I - Name

The name of this organization is the Medical Staff of Rice Memorial Hospital.

Article II - Membership

2.1 Nature of Membership

No practitioner shall be entitled to membership on the medical staff or to clinical privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

No physician, oral surgeon, or podiatrist, including those in a medical administrative position by virtue of a contract with the hospital, shall admit or provide medical or health-related services to patients in the hospital unless he/she is a member of the medical staff or has been granted telemedicine, locum tenens or temporary privileges in accordance with the procedures set forth in these bylaws. Appointment to the medical staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

2.2 Qualifications for Membership and/or Privileges

2.2-1 General Qualifications

Appointment to the Medical Staff is a privilege, which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in such policies as are adopted from time to time by the Board.

Only physicians, oral surgeons, and podiatrists who:

A. Are Board Certified (physicians only, with these caveats): (1) Existing members of the Active Medical Staff will be governed by the requirements in effect at the time of their initial appointment; (2) New physicians granted privileges to Rice Memorial Hospital Active Medical Staff must be Board Certified or have completed their American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA) or American Board of Physician Specialties (ABPS) Board Certification within 3 years; (3) If Board Certification lapses for any Active Medical Staff physician, privileges could be extended for up to 2 years without Executive Committee action; (4) Other requirements may be instituted by individual medical staff departments in their Department Criteria;

B. Document their (1) current Minnesota licensure, (2) Current DEA registration (if applicable) with a Minnesota address (2) adequate experience, education and training, (3) current (within the last 12 months) professional competence, (4) good judgment, and (5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care. Exceptions will be considered by the Medical Executive Committee on a case by case basis.

C. Are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff; (5) to be under no current sanctions or exclusion from participation in any federal or state program providing healthcare benefits, and (6) have not been convicted of any crime related to the practice of a healthcare profession, controlled substance, or fraud or abuse involving any federal or state program;

D. Maintain in force professional liability insurance in amounts not less than $1,000,000/$3,000,000 or as from time to time may be jointly determined by the Board of Directors in consultation with the Medical Executive Committee;

shall be deemed to possess basic qualifications for membership in the medical staff, except for the honorary staff categories in which case these criteria shall only apply as deemed individually applicable by the medical staff.

Failure to meet the qualifications listed in B(1), C(5), C(6), and D above shall result in automatic termination of Medical Staff appointment and shall not entitle the physician to any opportunity for review as provided in these Bylaws.

2.2-2 Particular Qualifications

A. Physicians

An applicant for physician membership in the medical staff, except for the honorary staff, must hold an MD or DO degree or their equivalent and a valid and unsuspended license to practice medicine issued by the Minnesota Board of Medical Practice. For the purpose of this Article, “or their equivalent” shall mean any degree (e.g. foreign) recognized by the licensing boards in the State of Minnesota to practice medicine. These individuals will have a graduate degree from an approved institution and will have completed an approved residency or will have passed appropriate foreign medical school exams with Educational Commission for Foreign Medical Graduates (ECFMG) certification.

B. Oral Surgeons

An oral surgeon must be licensed to practice by the Minnesota Board of Dentistry and must have completed an approved residency in oral and maxillofacial surgery.

C. Podiatrists

A podiatrist must be licensed to practice by the Minnesota Board of Podiatric Medicine and must have completed a podiatric residency approved by the Council on Podiatric Medical Education (CPME) or another recognized accrediting body accepted by the CPME.

2.3 Effect of Other Affiliations

No person shall be entitled to membership in the medical staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, has been hired by or has a contract with the Hospital, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in contracts with a third party which contracts with this hospital. Similarly, one who is otherwise qualified may not be denied membership solely because he/she is not a member of a particular professional society; however, this is not to be interpreted as preventing a requirement of relevant board certification or equivalency by one or more Medical Staff departments for those who may wish to be members within that department.

2.4 Nondiscrimination

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, marital status, familial status, sexual orientation, status with regard to public assistance, or disability that does not pose a threat to the quality of patient care.

2.5 Basic Rights of Medical Staff Membership

Except for the honorary staff, the basic rights of each member of the active medical staff as provided in these bylaws include:

A. The right to meet with the Medical Executive Committee.

B. The right to initiate recall of a medical staff officer.

C. The right to petition for a general medical staff meeting.

D. The right to petition for a department meeting.

E. The right to petition for a change to a rule or policy.

2.6 Basic Responsibilities of Medical Staff Membership

Except for the honorary staff, the ongoing responsibilities of each member of the medical staff include:

A. Maintaining the confidentiality, privacy and security of all protected health information (PHI) maintained by Rice Memorial Hospital or by any business associates of Rice Memorial Hospital. Confidentiality is maintained in accordance with all privacy and security policies and procedures adopted by Rice Memorial Hospital to comply with current Federal, State and local laws and regulations, including, but not limited to, the HIPAA Privacy Regulations. PHI will not be requested, accessed, used, shared, removed, released or disclosed except in accordance with Rice Memorial Hospital's health information privacy policies and applicable law. Information about a patient whom a Medical Staff member

is treating may be shared by the member with any other Medical Staff member who has responsibility for that patient's care. Information can also be shared with any other non-Medical Staff member provider who will be participating in the patient's care.

Passwords used by a member of the Medical Staff to access PHI from Rice Memorial Hospital records will be used only by said member, who will not disclose the password to any other individual (except authorized staff if needed for investigative purposes). The use of the member's password is equivalent to the member's electronic signature. Any misuse of a Rice Memorial Hospital computer system or information from a system may, in addition to any sanctions approved by the Rice Memorial Hospital Board of Directors regarding security measures, be a violation of State and Federal law and may result in denial of payment under Medicare;

B. Providing patients with the quality of care meeting the professional standards of the community and medical staff of this hospital;

C. Abiding by the medical staff bylaws and medical staff rules and regulations;

D. Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of medical staff membership, including peer review and committee assignments;

E. Preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the hospital;

F. Abiding by the lawful ethical principles of the American Medical Association (or equivalent professional related to the member's professional discipline);

G. Aiding in any medical staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel;

H. Working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care;

I. Making appropriate arrangements for coverage for his or her patients as determined by the medical staff;

J. Avoiding or refusing to engage in illegal conduct that relates to moral turpitude or the practice of a health care profession, including but not limited to, improper inducements for patient referral;

K. Participating in continuing education programs as determined by the medical staff;

L. Participating in such emergency service coverage or consultation panels as may be determined by the medical staff;

M. Discharging such other staff obligations as may be lawfully established from time to time by the medical staff or Medical Executive Committee;

N. Providing information to and/or testifying on behalf of the medical staff or an accused practitioner regarding any matter under an investigation and those which are the subject of a hearing pursuant to these bylaws;

O. Responding to a call from a patient care area regarding one of their patients as per Provider Contact Procedure. Individual departments may set stricter response requirements. When appropriate, response to such calls may be made by a physician covering call for the physician's group.

2.7 Leave of Absence

2.7-1 Leave Status

A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities longer than 30 calendar days if such absence is related to the individual's physical or mental health or to his/her ability to care for patients safely and competently.

At the discretion of the Medical Executive Committee, a medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written notice to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed six months. A single renewal for an additional six months of leave of absence may be submitted to the Medical Executive Committee via written request specifying the reason. In either situation, the leave of absence must end before the current term of membership ends. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff.

2.7-2 Termination of Leave

As early as possible prior to termination of the leave of absence, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee, including a summary of relevant activities during the leave. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and peer references will be required. These peer references will be obtained from peers with current knowledge of the applicant's competence (from within the past 12 months); if none are available, the MEC will determine requirements for assessing competency on a case-by-case basis. Any leave of absence longer than the allowances described in 2-7.1 above require full reapplication for credentials and privileges.

2.7-3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic

termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in these bylaws for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Article III - Categories of Membership

3.1 Categories

The categories of the medical staff shall include the following: active, affiliate, and honorary. Upon initial appointment to the Medical Staff and at each time of reappointment, the member's staff category shall be determined.

3.2 Active Staff

3.2-1 Qualifications

The active staff shall consist of members who:

A. Meet the general qualification for membership set forth in these bylaws;

B. Are active within the hospital either by having a practice which requires regular use of the hospital facilities or by being active on committees.

3.2-2 Prerogatives

Except as otherwise provided, the prerogatives of an active staff member shall be to:

A. Admit patients and exercise such clinical privileges as are granted pursuant to these bylaws;

B. Attend and vote on matters presented at general and special meetings of the medical staff and of the department and committees of which he or she is a member; and

C. Hold staff or department office and serve as a voting member of committees to which he or she is duly appointed or elected by the medical staff or duly authorized representative thereof.

D. Possess medical staff membership without requesting specific privileges.

3.2-3 Transfer of Active Staff Member

After two consecutive years in which a member of the active staff fails to regularly care for patients in this hospital or be regularly involved in medical staff functions as determined by the medical staff, that member may be transferred to another appropriate category, if any, for which the member is qualified.

3.3 Affiliate Staff

3.3-1 Qualifications

The affiliate medical staff shall consist of members who:

A. Meet the general qualification for membership set forth in these bylaws;

B. Have limited hospital activity and who have an ongoing interest in serving patients in our area;

C. Supply documentation of appropriate quality assurance activity for medical staff privileges desired.

3.3-2 Prerogatives

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

A. Admit patients in accordance with their medical staff privileges; and

B. Serve on medical staff committees in a voting capacity, and attend open committee meetings and educational programs.

C. Possess medical staff membership without requesting specific privileges.

3.3-3 Limitations

A. Affiliate medical staff members shall not be eligible to hold office in the medical staff, except affiliate medical staff members may serve as a department chair consistent with these bylaws.

B. Affiliate medical staff members may be required to attend staff/quality review meetings upon request.

C. Any affiliate medical staff member who attends, admits, or is involved in the care of more than fifteen (15) inpatients per year at the hospital shall be reviewed by the Medical Executive Committee. The Medical Executive Committee may choose to require active medical staff membership on a case-by-case basis.

D. After two consecutive years in which a member of the affiliate staff with clinical privileges fails to care for patients in the hospital or be involved in medical staff functions at least minimally as determined by the Medical Executive Committee, that member may be transferred to the honorary medical staff, if qualified, or may be asked to resign from the affiliate medical staff.

3.4 Honorary Staff

3.4-1 Qualifications

The honorary medical staff shall consist of physicians, oral surgeons or podiatrists (whether or not retired) who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

3.4-2 Prerogatives

Honorary medical staff members have no medical staff privileges but may serve on committees with or without vote at the discretion of the Medical Executive Committee, and may attend staff and department meetings, including open committee meetings and educational programs.

3.5 Limitation of Prerogatives

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other Articles of these bylaws and by the Medical Staff Rules and Regulations.

3.6 General Exceptions to Prerogatives

Exceptions may be approved at the discretion of the Medical Executive Committee.

3.7 Modification of Membership

On its own, upon recommendation of the Credentials Committee, or pursuant to the request by a member under these bylaws, the Medical Executive Committee may recommend a change in the medical staff category of a member consistent with the requirements of the bylaws.

Article IV - Appointment and Reappointment

4.1 General

Except as otherwise specified herein, no person (including persons engaged by the hospital in administratively responsible positions) shall exercise clinical privileges in the hospital unless and until that person applies for and receives appointment to the medical staff or is granted temporary privileges as set forth in these bylaws. Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these bylaws.

4.2 Burden of Producing Information

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information, and, in general, demonstrating his/her compliance with all applicable standards and eligibility for staff membership and clinical privileges. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee which may select the examining physician.

4.3 Appointment Authority

Appointment, denials, and revocations of appointments to the medical staff shall be made as set forth in these bylaws, but only after there has been a recommendation from the medical staff.

4.4 Duration of Appointment and Reappointment

Unless otherwise provided in these Bylaws, initial appointments and reappointments to the medical staff shall be for a period of two years unless a recommendation for modification is made by the MEC.

4.5 Application for Initial Appointment and Reappointment

4.5-1 Application Form

Each application for initial appointment to the medical staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), along with a valid and current hospital picture identification or government-issued picture identification, and signed by the applicant. Application forms shall be approved by the Medical Executive Committee. The form shall require detailed information as applicable including, but not limited to, information concerning:

A. The applicant's qualifications, including, but not limited to, professional education, training and experience, current licensure, current DEA registration, current Board certification, hospital affiliation history and employment history.

B. Peer references – (minimum of two) who have knowledge of the applicant's professional competence and ethical character from within the past 12 months (or have been responsible for professional observation of applicant's work) including their current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism;

C. Requests for membership categories, departments, and clinical privileges;

D. Past or pending professional disciplinary action, licensure limitations, or related matters, including challenges to any licensure or registration, voluntary and involuntary termination of medical staff membership, and voluntary and involuntary limitation, reduction, or loss of clinical privileges;

E. Current physical and mental health status demonstrating to the satisfaction of the medical staff, professional competence to perform the privileges requested so that patients treated by them can reasonably expect to receive quality medical care;

F. Final judgments or settlements made against the applicant in professional liability cases, and any filed cases pending; and

G. Certificate documenting professional liability insurance in an amount required by the Hospital. (See Article 2.2-1 D)

When an applicant requests an application form, that person shall have access to a copy of these bylaws, the medical staff rules and regulations, and other documents as applicable.

4.5-2 Effect of Application

By applying for appointment to the medical staff each applicant:

A. Signifies willingness to appear for interviews in regard to the application;

B. Authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

C. Consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspections and copying;

D. Releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in good faith in connection with investigating and evaluating the applicant;

E. Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

F. Consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the hospital or medical staff may have, and releases the medical staff and hospital from liability for so doing to the fullest extent permitted by law;

G. If a requirement then exists for medical staff fees or dues, acknowledges responsibility for timely payment;

H. Pledges to provide for continuous quality care for patient;

I. Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral in conformity with all state and federal legal standards, refraining from improper patient discharges or transfers, providing continuous care of his/her patients, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services and refraining from delegating patient care responsibility to nonqualified or inadequately supervised practitioners;

J. Acknowledges responsibility to first review these bylaws and agrees that throughout the application process and any period of membership that he/she shall comply with the responsibilities of medical staff membership and with the bylaws and rules and regulations of the medical staff as they exist and as they may be modified from time to time;

K. Agrees to submit to a physical or psychological evaluation to determine ability to exercise privileges requested, if requested by the Medical Executive Committee.

4.5-3 Verification of Information

The applicant shall deliver an application to the medical staff office and an advance payment of medical staff dues or fees, as required. The administrator shall be notified of the application. The Credentialing Specialist shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The hospital's authorized representative shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the Credentials Committee for inclusion in the applicant's or member's credentials file. Individuals seeking Honorary Staff membership will not be included in the query to the National Practitioner Data Bank. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information. When collection and verification is accomplished, the application is considered complete. The application and all supporting materials shall be transmitted to the appropriate department(s) or the Chief Medical Officer and then to the Credentials Committee.

4.5-4 Department Action

After receipt of the complete application, the chair of each department to which the application is submitted, shall review the application and supporting documentation for Active Staff (including locum tenens) applicants, and may conduct a personal interview with the applicant at the chair's discretion. The

chair shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted. The Chief Medical Officer (CMO) shall review and evaluate applications to the Affiliate or Allied Health Staff. The department chair or Chief Medical Officer shall transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The chair or CMO may also request that the Medical Executive Committee defer action on the application.

4.5-5 Credentials Committee Action

The Medical Executive Committee, convened as the Credentials Committee, shall review the application, evaluate and verify the supporting documentation, the department chair's or Chief Medical Officer's report and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. Since the Credentials Committee is composed of the same membership as the Medical Executive Committee, its recommendations and actions shall be considered those of the Medical Executive Committee.

4.5-6 Medical Executive Committee Action

The Medical Executive Committee shall forward to the administrator, for prompt transmittal to the Board of Directors, a written report and recommendation as to medical staff appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application. The reasons for each recommendation shall be stated.

4.5-7 Effect of Medical Executive Committee Action

A. Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Board of Directors.

B. Adverse Recommendation: When a final recommendation of the Medical Executive Committee is adverse to the applicant, the Board of Directors and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to the procedural rights as provided in these bylaws.

4.5-8 Action on the Application

Unless the applicant has initiated the review process under these bylaws, the Board of Directors may either accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

A. If the Medical Executive Committee issues a favorable recommendation, the Board of Directors may either affirm or dispute the recommendation of the Medical Executive Committee.

1. If the Board of Directors concurs with the recommendation, the decision of the board shall be deemed final action.

2. If the tentative final action of the Board of Directors is unfavorable, the administrator shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in these bylaws. If the applicant waives his or her procedural rights, the decision of the Board of Directors shall be deemed final action

B. In the event the recommendation of the Medical Executive Committee, or any significant part of it, is unfavorable to the applicant the procedural rights set forth in these bylaws shall apply.

1. If the applicant waives his or her procedural rights, the recommendations of the Medical Executive Committee shall be forwarded to the Board of Directors for final action, which may either affirm or dispute the recommendation of the Medical Executive Committee.

2. If the applicant requests a hearing following the adverse Medical Executive Committee recommendation or an adverse Board of Directors tentative final action, the Board of Directors shall take final action only after the applicant has exhausted his or her procedural rights as established by these bylaws. After exhaustion of the procedures set forth in these bylaws, the Board shall make a final decision, based upon the decision of the judicial review committee so long as it is fairly reached and based upon substantial evidence. The Board's decision shall be in writing and shall specify the reasons for the action taken.

4.5-9 Notice of Final Decision

A. Notice of the final decision shall be given to the applicant, Chief of Staff and the administrator.

B. A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

C. Applicant will be informed of the Governing Board decision within 10 days.

4.5-10 Reapplication after Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the medical staff for a period of one year. Any such reapplication shall be processed as an initial application, and the applicant

shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.5-11 Timely Processing of Applications

All individuals and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely manner and in good faith. Except for good cause, each application will be processed within 180 calendar days or 30 days after conclusion of hearings. These time periods are deemed guidelines and do not create any right for the practitioner to have an application processed within these time periods.

4.6 Reappointments, Requests for Renewal or Modification of Clinical Privileges or Modifications of Staff Status

4.6-1 Application

A. At least four (4) months prior to the expiration date of the current staff appointment, a reapplication form approved by the Medical Executive Committee shall be mailed or delivered to the individual by Medical Staff Services. At least 45 days prior to the expiration date, each medical staff member shall submit to the Credentials Committee the completed application form for renewal of appointment to the staff for the coming two years, and/or for renewal or modification of clinical privileges. If an application is not received at least 45 days prior to the expiration date, the process outlined in Section 4.6-4 will be followed. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the information required of initial applicants, as well as other relevant matters. Upon receipt of the application, the information shall be processed as required above for initial applicants.

B. A medical staff member who seeks an increase in medical staff status or clinical privileges may submit such a request at any time upon a form developed by the Medical Executive Committee, except that such application may not be filed within six months of the time a similar request has been denied. Medical staff members who wish to drop clinical privileges or decrease medical staff status may do so by stating in writing to the medical staff office the modification intended and the date the modification shall take effect.

4.6-2 Effect of Application

The effect of an application for reappointment or renewal or modification of staff status or privileges is the same as that set forth above for initial applicants.

4.6-3 Standards and Procedure for Review

For all providers granted clinical privileges, the Medical Staff Quality: Focused and Ongoing Professional Practice Evaluation policy will be followed. Where there is insufficient data regarding the privileges requested or previously granted, peer recommendations will be requested. When the member submits an application for modification of staff status or renewal or modification of clinical

privileges, the member shall be subject to an in-depth review generally following the procedures set forth above for initial applicants.

4.6-4 Failure to File Reappointment Application

Failure without good cause to timely file a completed application for reappointment shall result in the automatic discontinuation of admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff appointment. If an application for reappointment is not received at least 45 days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received and membership will be deemed resigned if said application is not received by 30 days prior to the expiration date of current privileges. If the member fails to submit a completed application for reappointment by the due date (30 days prior to the expiration date of the current appointment); the member shall be deemed to have resigned membership in the medical staff along with all clinical privileges. Written notice via certified mail shall be promptly sent to the member advising that the application has not been received resulting in termination of membership and/or clinical privileges upon expiration date. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise.

4.7 External Review for Appointment

External review, including monitoring, will take place in the context of investigation, application processing or at any other time only under the following circumstances, if and when deemed appropriate by the relevant department director, the Medical Executive Committee or, where the potential of conflicting interests within the medical staff is documented, by the Governing Body:

A. Ambiguity when dealing with vague or conflicting recommendations from the Credentials Committee where conclusion from this review could directly and adversely affect an individual's membership or privileges;

B. Lack of internal expertise, in that no one on the Medical Staff has adequate expertise in the clinical procedure or area under review;

C. When the Medical Staff needs an expert witness for a fair hearing, for evaluation of a credential file or for assistance in developing a benchmark for quality monitoring;

D. To promote impartiality in peer review;

E. Upon the reasonable request of a practitioner, when subject to focused review or investigation.

4.8 Expedited Credentialing

An expedited Board of Directors approval process may be used for applications for initial appointment and reappointment and/or for granting privileges when the processes delineated in Article 4.5-1 through 4.5-6 of these Bylaws have been completed.

The following situations are evaluated on a case-by-case basis. An applicant for privileges may be ineligible for the expedited process if any of the following has occurred:

A. There is a current or previously successful challenge to any professional licensure or registration
B. The applicant has received an involuntary termination of medical staff membership at any other organization
C. The applicant has received an involuntary limitation, reduction, denial, or loss of clinical privilege to date
D. There has been an excessive number or unusual pattern of professional liability actions resulting in final judgment against the applicant.

Qualifying applications are reviewed by the relevant department chair(s) or Chief Medical Officer and, if approved, by the Credentials Committee/Medical Executive Committee. If any of these medical staff authorities makes any adverse recommendation, the application is no longer eligible for expedition, and reverts to the regular application process. An expedited application may be acted upon by a committee of the Board, if permitted by hospital bylaws or policy.

Article V - Clinical Privileges

5.1 Exercise of Privileges

Except as otherwise provided in these bylaws, physicians, oral surgeons and podiatrists providing clinical services at this hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the criteria, rules and regulations of the clinical department and the authority of the department chair and the medical staff. Clinical privileges may be granted, continued, modified, or terminated by the governing body of this hospital only after consultation with the medical staff (except in the case of a summary suspension), only for reasons related to quality of patient care and other provisions of the medical staff bylaws, and only following the procedures outlined in these bylaws.

5.2 Delineation of Privileges in General

5.2-1 Requests

Each application for appointment and reappointment to the medical staff or request for privileges must contain a request for the specific clinical privileges desired by the applicant. A request for a modification of clinical privileges may be made at any time, but such request must be supported by documentation of training and/or experience supportive of the request.

5.2-2 Basis for Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the individual's education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the medical staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

5.2-2.1 The initial application shall contain a request for specific clinical privileges desired. The applicant has the burden of establishing his/her qualifications and competency to perform requested clinical privileges.

5.2-2.2 Applicants for reappointment shall have their clinical privileges reviewed and adjusted based on direct observation of care provided, review of patient records, quality assurance reports and medical staff records which document the evaluation of the applicants' delivery of care.

5.3 Monitoring and Certification

5.3-1 Monitoring

Except as otherwise determined by the Medical Executive Committee, all providers granted new clinical privileges shall have their practice activities monitored. The monitoring of practice activities shall be carried out in accord

with the Focused Professional Practice Evaluation (FPPE) as described in the policy Medical Staff Quality: Focused and Ongoing Professional Practice Evaluation. Additional monitoring may include direct observation of patient care activities and treatment procedures, chart review, and any other appropriate means. The monitoring of a staff member shall be sufficient to evaluate the individual's knowledge and proficiency, and the Department Chair or Chief Medical Officer and his/her designee shall certify the Staff Member's compliance with the standards of practice in the community and in this hospital, and conformity with the Bylaws and the Medical Staff Rules and Regulations.

5.3-2 Failure to Satisfy Monitoring Measures

If an initial appointee, or practitioner granted new privileges, fails to satisfy the monitoring measures required within the FPPE process, or if a member exercising new clinical privileges fails to satisfy the monitoring measures and to furnish such certification within the time allowed, those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to these bylaws.

5.3-3 Medical Staff Advancement

The failure to satisfy the monitoring measures for any specific clinical privileges shall not, of itself, preclude advancement in medical staff category of any member. If such advancement is granted absent a decision regarding another privilege or privileges, monitoring of the privilege(s) shall continue for the specified time period.

5.4 Temporary Clinical Privileges and Locum Tenens Privileges

5.4-1 Temporary Clinical Privileges

A. In cases of medical necessity, temporary clinical privileges may be granted to a licensed practitioner for the care of specific patients or to fulfill important patient care needs:

1. Patient: Clinical needs will not be adequately met if the temporary privileges under consideration are not granted.

2. Hospital: The hospital cannot adequately meet the needs of patients who seek care

3. Community: The community is at risk of not receiving appropriate patient care.

B. Temporary clinical privileges may be granted while awaiting completion of the approval process unless applicant is ineligible due to:

1. Current or previously successful challenge to licensure or registration

2. Involuntary termination of medical staff membership at another organization

3. Involuntary limitation, reduction, denial or loss of clinical privileges

5.4-2 Locum Tenens Privileges

Locum Tenens Privileges may be granted to a licensed practitioner to fulfill important patient care needs.

5.4-3 Procedure and Time Period

Temporary clinical privileges or Locum Tenens privileges may be granted, provided that the procedures in Section 4.5-1 through 4.5-3 have been followed.

A. Temporary clinical privileges may be granted for a time period not to exceed 120 days.

B. Locum Tenens privileges may be granted for a time period not to exceed twelve (12) months, unless the Department Chair or Medical Executive Committee recommends a longer period for good cause.

5.4-4 Application and Review

A. Upon review of the completed application and supporting documentation from a practitioner authorized to practice in Minnesota, the administrator, or designee, on behalf of the Board of Directors may grant temporary privileges to a member who appears to have qualifications, ability and judgment consistent with these Bylaws, but only after:

1. The applicant's file and supporting documentation are reviewed by the Department Chairperson or Chief Medical Officer. The recommendations of the Department Chairperson/Chief Medical Officer are forwarded to the Vice-Chief of Staff (Credentials Committee Chair).

2. Reviewing the applicant's file and attached materials, the Medical Executive Committee through the Vice-Chief of Staff or another designee recommends that the Administrator or designee grant or deny temporary privileges.

3. In the event of a disagreement between the Board of Directors and the Medical Executive Committee regarding the granting of temporary clinical privileges, the matter shall be resolved as set forth in these bylaws.

B. If the applicant requests temporary privileges in more than one department, application review and written concurrence shall be obtained from the appropriate department chairs prior to forwarding to the Vice-Chief of Staff.

5.4-5 General Conditions

A. If granted temporary privileges, the practitioner shall be under the supervision of the department chair to which the privileges holder has

been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to his or her activities within the hospital.

B. Requirements for monitoring shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the Vice Chief of Staff after consultation with the department chair or his/her designee.

C. All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

D. Temporary privileges may at any time be summarily suspended consistent with the terms of these bylaws. In such cases, the appropriate department chair or, in the chair's absence, the chair of the Medical Executive Committee, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

5.5 Emergency Care

In the case of an emergency, any member of the medical staff with clinical privileges, to the degree permitted by his or her license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the medical staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the hospital.

5.6 Telemedicine Services

5.6-1 Conditions

A. The term "telemedicine" shall mean licensed independent practitioners who prescribe, render a diagnosis, or otherwise provide clinical treatment to a patient at Rice Memorial Hospital through the use of electronic communication or other communication technologies from a distant site.

B. Services shall be provided via telemedicine only after a determination has been made by the Medical Staff that the clinical service involved would be appropriately delivered through this medium according to commonly accepted quality standards.

C. A Minnesota licensed independent practitioner may, without applying for membership on the Medical Staff, be granted privileges to provide telemedicine services at Rice Memorial Hospital. No privileges shall be granted for services not performed at Rice Memorial Hospital.

5.6-2 Medical Staff Membership

A. Telemedicine practitioners qualifying for service shall not be members of the Medical Staff. However, these practitioners shall be required to comply with all provisions of the Medical Staff Bylaws and Rules and Regulations, and all Rice Memorial Hospital policies applicable to the exercise of their clinical privileges.

5.6-3 Credentialing

Telemedicine practitioners are subject to the credentialing and privileging processes of Rice Memorial Hospital using one of the following methods:

A. Rice Memorial Hospital (originating site) fully privileges and credentials the practitioners according to the processes noted in Articles IV and V of these Medical Staff Bylaws; OR

B. Originating site privileges practitioners using credentialing information from the privileging organization of the telemedicine practitioner (distant site) if the distant site is a Joint Commission accredited organization. Distant site will provide the information noted in Article 4.5-1 and 4.5-2 of these Medical Staff Bylaws including documentation of primary source verification of this information. In addition, distant site will provide reference letters from three peer references of the applicant specific to the privileges requested at Rice Memorial Hospital. Rice Memorial Hospital staff will query the National Practitioner Data Bank and complete the credentialing and privileging process as noted in Articles 4.5-4 through 4.5-11 and Article V of the Rice Memorial Hospital Medical Staff Bylaws; OR

C. Originating site may choose to use the credentialing and privileging decision of the distant site to make a final privileging decision if the following provisions are met:

1. Distant site is a Joint Commission accredited organization

2. The practitioner is privileged at the distant site for those services to be provided at the originating site

3. Distant site provides originating site with a current list of practitioners' privileges.

4. Originating site completes internal review of the practitioner's performance of these privileges and sends to the distant site information useful to assess the practitioner's quality of care, treatment and services for use in privileging and performance improvement.

Rice Memorial Hospital's Governing Board grants privileges to the distant-site practitioner based on the originating site's medical staff recommendations, which rely on the information provided by the distant site.

5.6-4 Quality

A method to evaluate the services provided by the telemedicine practitioner will be established within the department using the telemedicine services. The Medical Staff Executive Committee will evaluate all telemedicine services for quality of services, timeliness and appropriateness. This evaluation will be conducted annually.

5.7 Modification of Clinical Privileges or Department Assignment

On its own or pursuant to a request under Article 4.6.1B, the Medical Executive Committee may recommend a change in the clinical privileges or department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current medical staff member be made subject to monitoring in accordance with procedures similar to those outlined in Article 5.3-1.

5.8 Lapse of Application

If a medical staff member requesting a modification of clinical privileges or department assignments fails to timely furnish the information necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article VIII.

5.9 Disaster Privileges

5.9-1 Circumstances

The Chief of Staff or the Administrator, or their designees, may grant disaster privileges only when the Hospital Emergency Management Plan has been activated and the hospital is unable to meet immediate patient needs. The medical staff bylaws, rules, regulations and policies apply to the exercise of disaster privileges.

5.9-2 Process

Individuals with disaster privileges are identified and managed as described in the Hospital Emergency Management Plan. The Chief of Staff or the Administrator, or their designees, may, on a case-by-case basis, grant disaster privileges upon presentation of a valid photo identification issued by a state or federal agency and at least one of the following:

A. A current Hospital picture identification that clearly identifies professional designation;

B. A current license to practice;

C. Primary source verification of the license;

D. Identification establishing that the individual is a member of a Disaster Medical Assistance Team (DMAT), MRC, ESAR-VHP, or other recognized state or federal organizations or groups;

E. Identification granted by a federal, state or municipal entity establishing that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances;

F. Identification by current hospital staff or medical staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

5.9-3 Post Disaster

Primary source verification of the license of individuals with disaster privileges begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

5.9-4 Medical Staff Oversight

The medical staff oversees the professional practice of the volunteer according to departmental rules and regulation, as established by the department in which privileges are held and approved by the Medical Executive Committee. The individuals listed above may withdraw disaster privileges at any time. Refusal or withdrawal of any disaster privileges does not give the right to the hearing and appeals process, unless the refusal or withdrawal results in a report to any state or national agency.

5.10 History and Physical Privileges

Only those granted privileges to do so conduct history and physicals or update histories and physicals. Privileges to admit include the privilege to conduct or update a history and physical. Privileges to conduct a history and physical or an update to a history and physical are granted only to:

A. Physicians

Privileges to conduct or update histories and physicals may be granted upon request to qualified physicians who are members of the medical staff or seeking temporary or locum tenens privileges.

B. Oral/Maxillofacial Surgeons/Podiatrists

Privileges to conduct or update histories and physicals only for those patients admitted solely for oral/maxillofacial surgery or podiatric surgery, consistent with the time requirements stated in this section may be granted upon request to qualified oral/maxillofacial surgeons or podiatrists, as applicable, who are members of the medical staff or seeking temporary privileges.

C. Allied Health Staff

Who may perform histories and physicals under the scope of their license.

Every patient receives a history and physical within twenty-four hours of admission, unless a previous history and physical performed within thirty days of admission is on record, in which case that history and physical will be updated within twenty-four hours of admission. Every patient admitted for surgery must have a history and physical within 24 hours prior to surgery, unless a previous history and physical performed within thirty days prior to the surgery is on record, in which case that history and physical will be updated within twenty-four hours of admission.

Article VI - Allied Health Staff

6.1 Qualifications

6.1-1 The Allied Health Staff means the licensed patient care providers other than physicians, oral surgeons, and podiatrists,(including, but not limited to, Advanced Practice Registered Nurses or Physician Assistants) who:

A. Have a practice which requires use of the hospital facilities;

B. Document their (1) current Minnesota licensure or certification, if appropriate, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

C. Are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as to not adversely affect patient care, (3) to keep confidential, as required by law, all information or records received in the provider-patient relationship, (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff, (5) to be under no current exclusion from participation in any federal or state program providing healthcare benefits, and (6) to have not been convicted of any crime related to the practice of a healthcare profession, controlled substance, or fraud or abuse involving any federal or state program;

D. Maintain in force professional liability insurance in an amount not less than $1,000,000/$3,000,000 or as from time to time may be jointly determined by the Board of Directors in consultation with the Medical Executive Committee.

Failure to meet the qualifications listed in B(1), C(5), C(6) and D above shall result in automatic termination of Allied Health staff appointment and shall not entitle the practitioner to any opportunity for review as provided in these Bylaws.

6.2 Conditions and Duration of Appointment

6.2-1 Application Process

Applicants for the Allied Health Staff shall submit an application for privileges in the same manner as an applicant for Medical Staff membership, provided that the application is on a special form as established by the Medical Executive Committee. All such applicants shall provide at least the following information in their application and decisions regarding privilege assignment shall be made based upon such information:

A. Formal education/training in the field in which privileges are desired;

B. Licensure or certification if appropriate;

C. Experience;

D. Privileges if desired;

E. Name of the clinical department or medical staff member and the degree of supervision under which the individual shall work. This is not applicable to an allied health practitioner who can practice independently;

F. Names of at least two persons who have knowledge of the applicant's professional competence and ethical character from within the past 12 months (or have been responsible for professional observation of applicant's work) including their current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism; and

G. Certificate documenting professional liability insurance in an amount required by the Hospital. (See Article 2.2-1 D)

6.2-2 Hospital Board Action

A. Initial appointments and reappointments to the allied health staff shall be made by the Hospital Board. The Hospital Board shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the medical staff as provided in these Bylaws, except as hereinafter provided.

B. Except in those circumstances described in Article 6.8-1, or in the case of a breach of the conditions set forth in Article 6.6, or in the case of failure to provide a certificate documenting professional liability insurance in an amount specified by the Board of Directors for each category of Allied Health Staff, the Hospital Board shall not take action on any application, refuse to renew an appointment, cancel an appointment previously made, or modify the privileges requested by the applicant without conference with the Medical Staff as hereinafter provided. Should the Hospital Board wish to take the initiative in refusing to appoint any applicant or make reappointments of any member, it shall so advise the Medical Staff, stating its reasons.

6.2-3 Duration of Appointment

Unless otherwise provided in these bylaws, initial appointments and reappointments shall be for a period of up to two years unless a recommendation for modification is made by the MEC.

6.2-4 Limitations

Appointment to the Allied Health Staff shall confer on the appointee only such privileges as have been granted by the Hospital Board in accordance with these Bylaws. The procedures relating to application, appointment and delineation of privileges shall be governed by the provisions of these Bylaws applicable to those matters as they relate to the Medical Staff.

6.3 Supervision

Supervision of allied health staff, except for those that can practice independently, shall be provided by physician chair of the assigned clinical department or by an individual medical staff member as assigned.

6.4 Scope of Activities

6.4-1 Privileges granted to Allied Health Staff shall be based on their education, training, experience, demonstrated competence and judgment, and the scope of their licensure when appropriate.

6.4-2 Allied Health Staff may admit and discharge patients to the extent allowed by the Medical Staff within the scope of their licensure and applicable statutes.

6.4-3 Allied Health Staff may participate directly in the management of patients and may exercise independent judgment within their area of competence, with the ultimate responsibility for patient care being shared by a member of the Medical Staff.

6.4-4 Allied Health Staff members may record the history & physical and progress notes in the appropriate area of the medical record.

6.4-5 Privileges to write orders with and without immediate consultation with the supervising Member, if any, shall be delineated.

6.4-6 Allied Health Staff shall follow the requirements outlined in Section B of the Medical Staff Rules and Regulations.

6.4-7 All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

6.5 Activities with the Medical Staff

Attendance at the Medical Staff meetings shall be at the discretion of the Chief of the Medical Staff and the Administrator. Allied Health Staff personnel may vote but may not hold office. They may be asked to serve on committees of the Medical Staff organization.

6.6 Reports of Disciplinary Action

Any practitioner subject to state licensure shall immediately report any warning, reprimand, fine, probation, suspension or revocation action taken against him/her by the involved licensing authority to the Administrator and the Chief of the Medical Staff.

6.7 Conformity to Hospital Standards

All Practitioners shall conduct themselves within the Hospital in accord with these Bylaws, the Medical Staff Rules and Regulations, and all applicable hospital policies, and shall accept and carry out committee assignments and other duties as allowed or required under these Bylaws, and shall participate in continuing education activities.

6.8 Reduction or Termination of Privileges

6.8-1 Without Cause

In the event the hospital department to which an Allied Health Staff member is assigned ceases to function or fails to supervise the Allied Health Staff member, or the Medical Staff member to whom an Allied Health Staff member is assigned ceases to practice at the hospital or fails to supervise the Allied Health Staff member, the Allied Health Staff member's privileges shall thereby automatically terminate. In this event, the termination of privileges shall be without prejudice to his or her eligibility for privileges and, subject to the ongoing criteria and standards for appointment, the Allied Health Staff member shall be eligible for appointment in the event a department or member is able to provide the required supervision; however, if another qualified Medical Staff member agrees to become the responsible physician for an Allied Health Staff member whose original responsible physician is no longer on staff or able to provide adequate supervision, the Credentials Committee may recommend a transfer of responsibility to the willing physician without requiring a new application from the Allied Health Staff member.

6.8-2 Breach of Standards

In the event that an Allied Health Staff member to whom privileges have been granted is perceived to be performing below hospital standards, in deviation from the standards of his or her profession, or in violation of the Medical Staff Bylaws and Rules and Regulations, such person shall be subject to one or more of the following remedies: a warning; reprimand; remedial, corrective or rehabilitative action; suspension or revocation of privileges; or denial of an application for reappointment; provided, that this shall not be construed to require "progressive discipline." In this event, the individual shall be entitled and subject to the same review and appeal procedures that would apply to a Member under similar circumstances. Actions related to any provider (physician or Allied Health Staff) must be reported to the National Practitioner Data Bank in compliance with its rules.

6.9 Hospital Employees

A Hospital employee or prospective employee who performs or shall perform the same services as those performed by a person on the Allied Health Staff shall be evaluated and dealt with by the Hospital under the same performance standards (but not necessarily using the same procedural standards) as such comparable Allied Health Staff personnel.

Article VII - Medical Staff Code of Conduct

7.1 Harassment Prohibited

As a condition of membership and privileges, a medical staff member shall continuously meet these requirements for professional conduct established in these bylaws. Privilege holders will be held to the same conduct requirements as members.

7.2 Acceptable Conduct

Acceptable medical staff member conduct is not restricted by these bylaws and includes:

A. Patient advocacy;

B. Recommendations or criticism intended to improve care;

C. Exercising rights granted under the medical staff bylaws, rules and regulations, and policies;

D. Fulfillment of duties of medical staff membership or leadership;

E. Legitimate business activities that may or may not compete with the Hospital.

7.3 Disruptive and Inappropriate Conduct

Disruptive and inappropriate medical staff member conduct is conduct that affects or could affect the quality of care of patients and/or undermines a culture of safety at the Hospital and includes but is not limited to:

A. Harassment by a medical staff member against any individual involved in the Hospital (e.g., against another medical staff member, house staff, Hospital employee or patient) for any reason, including, but not limited to race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated.

B. “Sexual harassment”, defined as unwelcome verbal or physical conduct of a sexual or gender-based nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as display of derogatory cartoons, drawings, or posters). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluations, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual’s employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct that indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

C. Deliberate physical, visual or verbal intimidation or challenge, including disseminating threats or pushing, grabbing or striking another person involved in the Hospital;

D. Carrying a gun or other weapon in violation of the hospital policy Weapons and Contraband.

E. Refusal or failure to comply with these member conduct requirements.

All allegations of harassment shall be immediately investigated by the medical staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of medical staff privileges or membership, if warranted by the facts.

7.4 Medical Staff Conduct Complaints

Complaints or reports of disruptive and inappropriate conduct by medical staff members are subject to review whether or not the witness or complainant requests or desires action to be taken. Complaints or reports must be in writing, and will be transmitted to the Chief of Staff or to the medical staff officer designated by the Chief of Staff or Medical Executive Committee. Complaints are shared with the subject member, who will be given the opportunity to respond to the officer or, if referred, the Committee handling the complaint. The Chief of Staff shall refer the matter to the Provider Health Committee for evaluation immediately if there is any indication that the member's health is implicated. The Chief of Staff shall determine if the complaint or report is obviously without merit and warrants no further action. If the Chief of Staff determines no action is warranted, the decision is reported at the next Medical Executive Committee in executive session, and may be discussed and acted upon at the request of any Medical Executive Committee member. Complaints not referred to the Provider Health Committee or dismissed by the Chief of Staff are referred to the appropriate department for evaluation or to the Medical Executive Committee for consideration of investigation and corrective action.

7.5 Complaints Concerning Hospital Staff

Medical staff members' reports or complaints about any hospital administrators, nurses or other employees, contractors, board members or others affiliated with the hospital must be presented in writing and submitted to the Chief of Staff, any medical staff officer, or appropriate hospital staff. The Chief of Staff shall forward the complaint or report to the appropriate hospital authority for action. Reports and complaints regarding hospital staff conduct will be referred to the executive responsible for that person (including the Chairperson of the Hospital Board of Directors for issues involving the Chief Executive Officer) who will report results of such reports and complaints to the Medical Executive Committee.

7.6 Abuse of Process

Retaliation or attempted retaliation against complainants or those who are carrying out medical staff duties regarding conduct will be considered inappropriate and disruptive conduct, and could give rise to evaluation and corrective action pursuant to the medical staff bylaws.

Article VIII - Corrective Action

8.1 Corrective Action

For purposes of this Article VIII, “member” includes those holding temporary privileges awarded pursuant to these Bylaws.

8.1-1 Criteria for Initiation

A. Any person may provide information to the medical staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the hospital; (2) unethical; (3) contrary to the medical staff bylaws and rules or regulations; (4) below applicable professional standards; or (5) a violation of law involving moral turpitude or the practice of the healing arts, a request for an investigation or action against such member may be initiated by the Chief of Staff, a department chair, or the Medical Executive Committee.

B. Prior to initiation of action under this Article, behavior that indicates that the member suffers from a physical, mental or emotional condition will be referred to the Provider Health Committee or otherwise evaluated to promote assisting the medical staff member while protecting others. Any actions required to protect physicians, staff, patients, or visitors shall be immediately undertaken.

8.1-2 Initiation

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

8.1-3 Investigation

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate medical staff officer, medical staff department, or standing or ad hoc committee of the medical staff, or may determine that no further investigation is warranted because the request for corrective action is adequately supported. The date on which the Medical Executive Committee or its delegate first meets to begin the investigation process shall be considered the official start date of the investigation. The Medical Executive Committee in its discretion may appoint practitioners who are not members of the medical staff as temporary members of the medical staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these practitioners temporary clinical privileges under these bylaws, should circumstances warrant. If the investigation is delegated to an officer or a committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable, but in

no event longer than 60 days. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such interviews shall not constitute a "hearing" as that term is used in these bylaws, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

8.1-4 Medical Executive Committee Action

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action which may include, without limitation:

A. Determining no corrective action is taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;

B. Deferring action for a reasonable time where circumstances warrant;

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

D. Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;

E. Recommending reduction, modification, suspension or revocation of clinical privileges;

F. Recommending reductions of membership status or limitations of any prerogatives directly related to the member's delivery of patient care;

G. Recommending revocation or probation of medical staff membership; and

H. Taking other actions deemed appropriate under the circumstances.

8.1-5 Subsequent Action

A. If corrective action that is recommended by the Medical Executive Committee constitutes grounds for hearing and appellate review under these bylaws, that recommendation shall be transmitted to the Board of Directors and to the member pursuant to these bylaws.

B. Providing the Board shall judge that the recommendation of the Medical Executive Committee is supported by substantial evidence, the recommendation shall be adopted by the Board as final action, unless the member requests a hearing pursuant in which case the final decision shall be determined as set forth in the hearing and appeals provisions of these bylaws. This final action is considered a Professional Review Action.

8.2 Summary Restriction or Suspension

8.2-1 Criteria for Initiation

Whenever a member's conduct appears to require that immediate action be taken to prevent imminent danger to the health of any patient, prospective patient, or other person, the Chief of Staff, the Medical Executive Committee, the chair of the department in which the member holds privileges, or the designee of any such authority may summarily restrict or suspend the medical staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the Board of Directors, the Medical Executive Committee and the Administrator. In addition, the affected medical staff member shall be provided with a written notice of the action which fully complies with the requirements of the hearing and appeals provisions below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chair or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

8.2-2 Written Notice of Summary Suspension

Within one working day of imposition of a summary suspension, the affected medical staff member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the member's privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Article 9.3-1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Article 9.3-1 may supplement the initial notice provided under this Article, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

8.2-3 Medical Executive Committee Action

Within one week after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee or a subcommittee appointed by the Chief of Staff shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning

the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of these bylaws, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two working days of the meeting, which notice shall also describe the member's procedural rights.

8.2-4 Procedural Rights

Unless the Medical Executive Committee terminates the summary restriction or suspension during the meeting which should occur within seven days of the action, the member shall be entitled to the procedural rights afforded by these bylaws. In addition, the affected member shall have the following rights:

A. Any affected member shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of imminent danger to an individual. Initially, the member may present this challenge to the Medical Executive Committee at the meeting held within one week of imposition of the suspension. If the Medical Executive Committee decision is to continue the summary suspension, then any member who has properly requested a hearing under the medical staff bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension. The hearing officer (or hearing panel) may, in its discretion, elect whether or not to bifurcate the hearing. Along with any other appropriate requests for rulings, the affected member may request that the hearing officer (or hearing panel) stay the summary suspension, pending the final outcome of the hearing and any appeal. The hearing officer (or hearing panel) may stay the summary suspension and if it does so, it may impose any less restrictive conditions or requirement that it deems appropriate under the circumstances.

B. At the conclusion of the procedural portion of the hearing, the hearing officer (or hearing panel) shall issue a written opinion on the issues raised, including whether or not facts which gave rise to the summary restrictions or suspension adequately support a determination that failure to summarily restrict or suspend could reasonably result in "imminent danger" to an individual. Such written opinion shall be transmitted to both the affected practitioner and the Medical Executive Committee within one week of the date of the procedural hearing.

C. If the hearing officer's (or hearing panel's) determination is that the facts stated in the notice required by Article 8.2-2 do not support a reasonable determination that failure to summarily restrict or suspend the member's privileges could result in imminent danger,

the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

D. If the hearing officer (or hearing panel) determines that the facts stated in the notice required by Article 8.2-2 support a reasonable determination that summary suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

8.3 Automatic Suspension or Limitation

In the following instances, the member's privileges or membership may be suspended or limited as described, and a hearing, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

8.3-1 Licensure

A. Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

B. Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

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

8.3-2 Controlled Substances

A. Whenever a member's DEA certificate is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

B. Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

8.3-3 Failure to Satisfy Special Appearance Requirement

Failure of a member without good cause to appear and satisfy the requirements under these bylaws for special appearance shall be a basis for corrective action.

8.3-4 Medical Records

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

8.3-5 Failure to Pay Dues/Assessments

Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments, as required under these bylaws, shall be grounds for automatic suspension of a member's clinical privileges, and if within six months after written warnings of the delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

8.3-6 Professional Liability Insurance

Failure to maintain professional liability insurance, as required, shall be grounds for automatic suspension of a member's clinical privileges, and if within 30 days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

8.3-7 Medical Executive Committee Deliberation

As soon as practicable after action is taken or warranted as described in this Article, the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth below.

Article IX - Hearings and Appellate Reviews

9.1 General Provisions

9.1-1 Exhaustion of Remedies

If adverse action is taken or recommended, the applicant or member must exhaust the remedies afforded by these bylaws before resorting to legal action.

9.1-2 Application of Article

For purposes of this Article, the term “member” may include “applicant,” as it may be applicable under the circumstances, unless otherwise stated.

9.1-3 Timely Completion of Process

The hearing and appeal process shall be completed within a reasonable time. Though this “reasonable time” may depend on external forces, the Medical Executive Committee should strive to complete this process within 90 days.

9.1-4 Final Action

Recommended adverse actions shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived.

9.2 Grounds for Hearing

Except as otherwise specified in these bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

A. Denial of medical staff membership;

B. Denial of requested advancement in staff membership status, or category;

C. Denial of medical staff reappointment;

D. Demotion to lower medical staff category or membership status;

E. Suspension of staff membership;

F. Revocation of medical staff membership;

G. Denial of requested clinical privileges;

H. Involuntary reduction of current clinical privileges;

I. Suspension of clinical privileges;

J. Termination of all clinical privileges; or

K. Involuntary imposition of significant consultation or monitoring requirements.

9.3 Requests for Hearing

9.3-1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Article 9.2, said person or body shall give the member prompt written notice of (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Minnesota Board of Medical Practice and the National Practitioner Data Bank, as required by applicable rules or laws; (2) the reasons for the proposed action including the acts of commission or omission with which the member is charged; (3) the right to request a hearing pursuant to these bylaws, and that such hearing must be requested with 31 days; and (4) a summary of the rights granted in the hearing pursuant to the medical staff bylaws, as detailed in sections 9.3-2 – 9.3-4, and including disclosure of the right to legal counsel.

This notice should be similar to this: "If you choose to have a hearing, you must notify us in writing within 31 days of your receipt of this letter. The Medical Executive Committee will schedule this hearing and give you notice of the time, place, and date of the hearing within 15 days of receipt of your request. You are, of course, entitled to legal representation before or after you respond and during the hearing. The hearing will be before a Judicial Review Committee of the Rice Memorial Hospital Board of Directors or their designees. The details of the hearing procedure are listed in Article 9.4 of the Bylaws, which defines prehearing requirements and options and describes the conduct of the hearing. Note that both sides can call, examine, and cross-examine witnesses. Appeal proceedings are detailed in the Bylaws, as well."

9.3-2 Request for Hearing

The member shall have 31 days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the Board of Directors. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

9.3-3 Time and Place for Hearing

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and, within 15 days give notice to the member of the time, place and date of the hearing. Unless extended by the judicial review committee, the date of the commencement of the hearing shall be not less than 30 days, nor more than 60 days from the date of the notice; provided, however, that when the request is received from a member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed 45 days from the date of receipt of the request.

9.3-4 Notice of Hearing

Together with the notice stating the time, place and date of the hearing, which date shall not be less than 30 days after the date of the notice unless waived by a member under summary suspension, the Medical Executive Committee or

Board, if its action is the cause of the hearing, shall provide a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee or the Hospital Board, if its action is the cause of the hearing. The content of this list is subject to update pursuant to these bylaws.

9.3-5 Judicial Review Committee

When a hearing is requested, the Medical Executive Committee shall recommend a judicial review committee to the Board of Directors for appointment. The Board of Directors shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objection within 5 days. Upon approval, the administrator shall notify the committee members of their appointment in writing. The judicial review committee shall be composed of not less than 5 members of the medical staff. Judicial review committee members shall gain no direct financial benefit from the outcome, and shall not have acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the judicial review committee. In the event that it is not feasible to appoint a judicial review committee from the medical staff, the Medical Executive Committee may recommend practitioners who are not members of the medical staff. Such appointment shall include designation of the chair.

9.3-6 Failure to Appear or Proceed

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

9.3-7 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted by the hearing officer on a showing of good cause, or upon agreement of the parties.

9.4 Hearing Procedure

9.4-1 Prehearing Procedure

A. If either side to the hearing requests in writing a list of witnesses, within 15 days of such request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, and shall also have the right to receive at least 30 days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the hospital or

medical staff. The member and the Medical Executive Committee shall have the right to receive all evidence which shall be made available to the Judicial Review Committee, and the member shall be provided with a copy of these Bylaws so as to be informed of his/her rights in these proceedings.

B. The Medical Executive Committee shall have the right to inspect and copy, at its expense, any documents or other evidence relevant to the charges which the member has in his or her possession or control as soon as practicable after receiving the request.

C. The failure by either party to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

D. The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

1. Whether the information sought may be introduced to support or defend the charges;

2. The exculpatory or inculpatory nature of the information sought, if any;

3. The burden imposed on the party in possession of the information sought, if access is granted; and

4. Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

E. The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer. Challenges to the impartiality of any judicial review committee member shall be ruled on by the hearing officer. Challenges to the impartiality of the Hearing Officer shall be ruled on by the Chief of Staff.

F. It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

9.4-2 Representation

The hearings provided for in these bylaws are for the purpose of intra professional resolution of matters bearing on professional conduct, professional competency, or character.

The member shall be entitled to representation by legal counsel in any phase of the hearing, should he/she so choose, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the state of Minnesota who is not also an attorney at law.

9.4-3 The Hearing Officer

The Medical Executive Committee shall recommend a hearing officer to the Board of Directors to preside at the hearing. The Board of Directors shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objections within 5 days. Upon approval, the administrator shall notify the Hearing Officer of the appointment in writing. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the hospital, the medical staff, or the involved medical staff member or applicant for membership, for legal advice regarding their affairs and activities, shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

9.4-4 Record of the Hearing

A stenographer or court recorder shall be present to make a record of the hearing proceedings, and the prehearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the stenographer or court recorder shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The judicial review committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath. A tape recording of the proceedings may also be utilized, if requested by either party.

9.4-5 Rights of the Parties within the Hearing

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called by the Medical Executive Committee, or the Board's representative, if the Board's action has occasioned the hearing, and examined as if under cross-examination.

9.4-6 Miscellaneous Rules

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

9.4-7 Burdens of Presenting Evidence and Proof

A. At the hearing the Medical Executive Committee or the Board, if the Board's action has occasioned the hearing, shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

B. An applicant shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of his/her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the medical staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

C. Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

9.4-8 Adjournment and Conclusion

After consultation with the chair of the judicial review committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due

consideration for reaching an expeditious conclusion to the hearing. Either the Medical Executive Committee or the Board, if the Board's action has occasioned the hearing and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

9.4-9 Basis for Decision

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the judicial review committee shall be subject to such rights of appeal as described in these bylaws.

9.4-10 Decision of the Judicial Review Committee

Within 30 days after final adjournment of the hearing, the judicial review committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be 15 days. A copy of said decision also shall be forwarded to the administrator, the Board of Directors, and to the member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. If the final proposed action adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days and is based on competence or professional conduct, the decision shall state that the action if adopted shall be reported to the Minnesota Board of Medical Practice, and shall state the text of the report as agreed upon by the committee. Both the member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the judicial review committee shall be subject to such rights of appeal or review as described in these bylaws. The Board of Directors shall then accept or reject the decision, which, barring appeal becomes the final action.

9.5 Appeal

9.5-1 Time for Appeal

Within 10 days after receipt of the decision of the judicial review committee, the member or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the other party and the administrator. If a request for appellate review is not requested within such period, the action of the Board of Directors shall be accepted as the final action.

9.5-2 Grounds for Appeal

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice; (b) the decision was not supported by substantial evidence based upon the hearing record or such additional

information as may be permitted pursuant to Article 9.5-5; (c) the text of the report to be filed to the Minnesota Board of Medical Practice is not accurate.

9.5-3 Time, Place and Notice

If an appellate review is to be conducted, the appeal board shall, within 15 days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than 30 nor more than 60 days from the date of such notice, provided however, that when a request for appellate review concerns a member who is under suspension which is then in effect, upon the member's request the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed 15 days from the date of the notice. The time for appellate review may be extended by the appeal board for good cause.

9.5-4 Appeal Board

The Board of Directors may sit as the appeal board, or it may appoint an appeal board which shall be composed of not less than 3 members of the Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney selected by the Board of Directors shall not be the attorney that represented either party at the hearing before the judicial review committee, or the person who served as the hearing officer.

9.5-5 Appeal Procedure

Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of his or her position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the judicial review committee decision, or remand the matter to the judicial review committee for further review and decision.

9.5-6 Decision

A. Except as provided below, within 30 days after the conclusion of the appellate review proceedings, the Board of Directors shall render a final decision and shall affirm the decision of the judicial review committee if the judicial review committee's decision is supported by substantial evidence, following a fair procedure.

B. Should the Board of Directors determine that the judicial review committee decision is not supported by substantial evidence, the board may modify or reverse the decision of the judicial review committee and may instead, or shall, where a fair procedure has not been afforded,

remand the matter to the judicial review committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the judicial review committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the Board of Directors. This further review and the time required to report back shall not exceed 30 days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the Board of Directors and the judicial review committee.

C. The decision shall be in writing, shall specify the reasons for the action taken, shall include the text of the report which shall be made to the Minnesota Board of Medical Practice, if any, and shall be forwarded to the staff, the Medical Executive and Credential Committees, the subject of the hearing, and the administrator, at least 10 days prior to submission to the Minnesota Board of Medical Practice.

9.5-7 Right to One Hearing

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

9.6 Exceptions to Hearing Rights

9.6-1 Appropriateness of Exclusive Contracts

Privileges can be reduced or terminated as a result of a decision to close or continue closure of a department/service pursuant to an exclusive contract, or to transfer an existing exclusive contract, and such actions are not subject to the hearing and review procedures unless the actions are taken for reasons relating to the quality of care provided by the adversely affected members.

9.6-2 Automatic Suspension or Limitation of Practice Privileges

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Article 7.3-1A. In other cases described in Articles 7.3-1 and 7.3-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the member may continue practice in the hospital with those limitations imposed.

9.6-3 Department/Service Formation or Elimination

A medical staff department/service may only be formed or eliminated providing the medical staff is given a sixty (60) day opportunity to comment upon the appropriateness of department/service elimination or formation with the communication to be forwarded in writing to the Board of Directors.

9.7 National Practitioner Data Bank Reporting

9.7-1 Adverse Actions

The authorized representative shall report an adverse action to the Minnesota Board of Medical Practice only upon its adoption as final action and only using the description set forth in the final action as adopted by the Board of Directors. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

9.7-2 Dispute Process

If no hearing was requested, a member who was the subject of an adverse action report may request an informal meeting to dispute the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the Chief of Staff, the chair of the subject's department, and the hospital's authorized representative, or their respective designees. If a hearing was held, the dispute process shall be deemed to have been completed.

Article X - Officers

10.1 Officers of the Medical Staff

10.1-1 Identification

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

10.1-2 Qualifications

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

10.1-3 Nominations

A. The medical staff election year shall be each even numbered year. A nominating committee shall be named in August of the election year. The nominating committee shall consist of the current Chief of Staff, Vice Chief of Staff, and one other member of the Medical Executive Committee. Should any of the named individuals be unable to serve on the nominating committee, they shall designate their own replacement. The nominating committee shall nominate one or more nominees for each office. The nominations shall be reported to the Medical Executive Committee at least 20 days prior to the scheduled election. The nominations shall also be communicated to the voting members of the medical staff at least 20 days prior to the scheduled election.

B. Further nominations may be made for any office by any voting member of the medical staff, provided that the name of the candidate is submitted in writing to the nominating committee and is accompanied by the candidate's written consent. Such nominations shall be delivered to the nominating committee as soon as reasonably practical, but at least 14 days prior to the scheduled election. Voting members shall be advised of the addition to the posted nominations at least 10 days prior to the scheduled election. Nominations from the floor shall be recognized only if the nominee is present and consents.

10.1-4 Elections

The Chief of Staff, Vice Chief of Staff, and Secretary-Treasurer shall be elected at a designated medical staff meeting during the fourth quarter of the election year by all members of the Active medical staff. Voting shall occur via ballot, written or electronic, and ballots shall be considered valid providing no more than one candidate per office is designated by the voter. A nominee shall be elected upon receiving a majority of the valid votes cast, providing the election results are approved by the Board of Directors. If no candidate receives the majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election at its next meeting or at a special meeting called for that purpose.

10.1-5 Term of Elected Office

Each officer shall serve a 2 year term, commencing on the first day of the medical staff year following his/her election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. At the end of that officer's term, the Chief of Staff shall automatically assume the office of immediate past Chief of Staff.

10.1-6 Recall of Officers

Any officer whose election is subject to these bylaws may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a medical staff officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least one-third of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a majority vote of the medical staff members eligible to vote for medical staff officers who actually cast votes at the special meeting in person or by mail or electronic ballot.

10.1-7 Vacancies in Elected Offices

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies, other than that of the Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of Chief of Staff, then the Vice Chief of Staff shall assume the duties of the Chief of Staff and shall immediately appoint an ad hoc nominating committee to seek a nominee(s) for the office of Chief of Staff. Such nominee(s) as may be found shall be reported to the Medical Executive Committee and to the medical staff. A special election to fill the position of Chief of Staff shall occur at the next regular staff meeting. In the event that no nominee can be found for the office of Chief of Staff, the Vice Chief of Staff shall continue serving as the Chief of Staff for the remaining term. If there is a vacancy in the office of either Vice Chief of Staff or Secretary-Treasurer, that office need not be filled by election, but the Medical Executive Committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of Chief of Staff.

10.2 Duties of Officers

10.2-1 Chief of Staff

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

A. Enforcing the medical staff bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

B. Calling, presiding at, and being responsible for the agenda of all meetings of the medical staff;

C. Serving as chair of the Medical Executive Committee;

D. Serving as an ex officio member of all other staff committees without vote, or with a vote if his/her membership in a particular committee is required by these bylaws;

E. Interacting with the administrator and Board of Directors in all matters of mutual concern within the hospital;

F. Appointing, in consultation with the Medical Executive Committee, committee members for all standing and special medical staff, liaison, or multi-disciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairs of these committees;

G. Representing the views and policies of the medical staff to the Board of Directors and to the Administrator;

H. Being a spokesperson for the medical staff in external professional and public relations;

I. Performing such other functions as may be assigned to the Chief of Staff by these bylaws, the medical staff, or by the Medical Executive Committee;

J. Serving on liaison committees with the Board of Directors and administration, as well as outside licensing or accreditation agencies.

10.2-2 Vice Chief of Staff

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee, shall serve as the chairman of the Credentials Committee, and shall perform such other duties as the Chief of Staff may assign as may be delegated by these bylaws, or by the Medical Executive Committee.

10.2-3 Secretary-Treasurer

The Secretary-Treasurer shall be a member of the Medical Executive Committee. The duties shall include, but not be limited to:

A. Maintaining a roster of members;

B. Keeping accurate and complete minutes of all Medical Executive Committee and general medical staff meetings;

C. Calling meetings on the order of the Chief of Staff or Medical Executive Committee;

D. Attending to all appropriate correspondence and notices on behalf of the medical staff;

E. Overseeing the medical staff funds, including collection of medical staff dues and approval of expenditures;

F. Performing such other duties as ordinarily pertains to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

G. Assuming the duties of the Chief of Staff and/or the Vice Chief of Staff when they are temporarily unavailable or unable to assume their duties.

10.2-4 Accountability

The medical staff officers are accountable through the Medical Executive Committee to the medical staff as a whole.

Article XI - Clinical Departments

11.1 Organization of Clinical Departments

The medical staff shall be divided into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities as specified in Article 11.5-5. When appropriate, the Medical Executive Committee may recommend to the medical staff the creation, elimination, modification, or combination of departments.

11.2 Current Departments

The current departments are: Anesthesiology, Emergency Medicine, Family Medicine**,** Internal Medicine, Obstetrics-Gynecology, Pathology, Pediatrics, Psychiatry, Radiology and Surgery.

11.3 Assignment to Departments

Each member shall be assigned membership in at least one department, but may also be granted membership and/or clinical privileges in other departments consistent with practice privileges granted.

Each Medical Staff Department shall formulate criteria which must be met for a physician, oral surgeon, or podiatrist to be included within their department, including the type of post-graduate education. Such criteria must be approved by the Credentials Committee.

11.4 Functions of Departments

The general functions of each department shall include:

A. Conducting patient care review for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The department shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department;

B. Recommending to the Medical Executive Committee the type of data to be collected for ongoing professional practice evaluation and the guidelines for the granting and monitoring of clinical privileges and the performance of specified services within the department which include consideration of ongoing professional practice evaluation information;

C. Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department;

D. Conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice;

E. Reviewing and evaluating departmental adherence to: (1) medical staff policies and procedures and (2) sound principles of clinical practice;

F. Coordinating patient care provided by the department's members with nursing and ancillary patient care services;

G. Submitting written reports to the Medical Executive Committee concerning: (1) the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and the hospital;

H. Meeting at least quarterly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities; as well as reports on other department and staff functions;

I. Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including monitoring protocols;

J. Setting clearly-defined triggers for indicating the need for performance monitoring;

K. Taking appropriate and consistent action when important problems in patient care and clinical performance or opportunities to improve care are identified;

L. Accounting to the Medical Executive Committee for all professional and medical staff administrative activities within the department; and

M. Formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the medical staff.

11.5 Department Chairs

11.5-1 Qualifications

Each department shall have a department chair who is a member of the active medical staff and who is certified by an appropriate specialty board or possesses comparable competence affirmatively established through the credentialing process qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the department. Upon approval of the Medical Executive Committee, a member of the affiliate medical staff who meets all other requirements may be appointed as chair of a department with all due voting rights.

11.5-2 Selection

Department chairs shall be elected every 3 years (unless a department shall choose a lesser term) by those members of the department who are eligible to vote for general officers of the medical staff using the same methodology as

discussed above (Article 10.1-4). Each department shall be free to follow whichever means of nominating and electing its chair as is acceptable to the majority of its members. Election of department chairs (and vice-chairs, if desired by a department) shall be reported to the Medical Executive Committee. Vacancies due to any reason shall be filled by the respective department with such mechanisms as that department may adopt.

11.5-3 Term of Office

Each department chair shall serve a 3 year term (or a lesser term if such has been selected by a department) which coincides with the medical staff year or until their successors are chosen, unless they resign, are removed from office, or lose their medical staff membership or clinical privileges in that department. Department officers shall be eligible to succeed themselves.

11.5-4 Removal

After election, removal of department chairs from office may occur for cause by either a majority vote of the Medical Executive Committee or a majority vote of the department members eligible to vote on departmental matters who cast votes.

11.5-5 Duties

Each chair shall have the following authority, duties and responsibilities:

A. Act as presiding officer at departmental meetings;

B. Report to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the department, including integration of the department or service into the primary functions of the organization;

C. Oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee. Develop and implement any needed policies and procedures that guide and support the provision of care, treatment, and services. Continually assess and improve the quality of care, treatment, and services. Maintain quality control programs, as appropriate;

D. Develop and implement departmental programs for retrospective patient care review, ongoing monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assurance;

E. Serve as a member of the Medical Executive Committee, and give guidance on the overall medical policies of the medical staff and hospital and make specific recommendations and suggestions regarding the department. Recommend a sufficient number of qualified and competent persons to provide care, treatment, and services;

F. Transmit to the Medical Executive Committee the department's recommendations concerning practitioner appointment and classification, reappointment, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the department;

G. Endeavor to enforce the medical staff bylaws, rules, policies and regulations within the department;

H. Implement within the department appropriate actions taken by the Medical Executive Committee;

I. Participate in every phase of administration of the department, including cooperation with the nursing service and the hospital administration in matters such as personnel, supplies, special regulations, standing orders and techniques. Coordinate and integrate interdepartmental and intradepartmental services;

J. Assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Medical Executive Committee;

K. Recommend delineated clinical privileges for each member of the department;

L. Assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;

M. Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

N. Provide for orientation and continuing education of all persons in the department or service; and

O. Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.

11.5-6 Accountability

The department chairs are accountable to the members of their department and to the Medical Executive Committee.

Article XII - Committees

12.1 Designation

Medical staff committees include, but are not limited to, the medical staff meeting as a committee of the whole, meetings of departments, meetings of other committees established under Article XI or in the Medical Staff Rules and Regulations, and meetings of special or ad hoc committees created by the Medical Executive Committee or by departments (pursuant to these bylaws). The committees described in this Article shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the Medical Executive Committees to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee. Medical staff committees shall be responsible to the Medical Executive Committee.

12.2 General Provisions

12.2-1 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of one year, and shall serve until the end of this period or until the member's successor is appointed, unless the member resigns or is removed from the committee. Reappointment may occur without limitation.

12.2-2 Removal

If a member of a committee ceases to be a member in good standing of the medical staff, or loses employment or a contract relationship with the hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Medical Executive Committee.

12.2-3 Vacancies

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

12.3 Medical Executive Committee

12.3-1 Composition

The Medical Executive Committee shall consist of the following persons:

A. The officers of the medical staff;

B. The department chairs;

C. The Chief Executive Officer and/or designees (ex-officio); and

D. The Chief Medical Officer.

Members of the active, affiliate, and allied health staff may be appointed as members of the Medical Executive Committee. The majority of voting Medical Executive Committee members shall be fully licensed doctors of medicine or osteopathy actively practicing in the Hospital.

12.3-2 Duties

The duties of the Medical Executive Committee include, but are not limited to:

A. Representing and acting on behalf of the medical staff in the intervals between medical staff meetings, subject to such limitations as may be imposed by these bylaws;

B. Coordinating and implementing the professional and organizational activities and policies of the medical staff;

C. Receiving and acting upon reports and recommendations from medical staff departments, committees, and assigned activity groups;

D. Recommending actions to the Board of Directors on matters of medical administrative nature, including recommendations on the structure of the organized medical staff;

E. Establishing the structure of the medical staff, the criteria to grant and the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance/quality improvement activities and mechanisms of the medical staff, termination of medical staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized medical staff;

F. Evaluating the medical care rendered to patients in the hospital;

G. Participating in the development of all medical staff and hospital policy practice, and planning;

H. Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the Board of Directors regarding staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;

I. Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in medical staff corrective or review measures when warranted;

J. Taking reasonable steps to develop continuing education activities and programs for the medical staff;

K. Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the medical staff and approving or rejecting appointments to those committees by the Chief of Staff;

L. Reporting to the medical staff at each regular staff meeting;

M. Assisting in the obtaining and maintenance of accreditation;

N. Developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;

O. Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the medical staff;

P. Reviewing the quality and appropriateness of services provided by contract physicians;

Q. Reviewing and approving the designation of the hospital's authorized representative for National Data Bank purposes;

R. Meeting with the Hospital Board, in whole or in part, to enhance communication and maintain a close liaison; and

S. Meeting with any medical staff member who requests an audience concerning said member's inability to resolve a difficulty working with his/her respective department or department chair. A timely request for such an audience should be sent in writing to the Chief of Staff or Chief Medical Officer.

12.3-3 Meetings

The Medical Executive Committee shall meet as often as necessary, but not less than 10 times per year and shall maintain a record of its proceeding and actions.

12.4 Credentials Committee

12.4-1 Composition

The Credentials Committee shall consist of the members of the Medical Executive Committee, with the Vice Chief of Staff serving as the chair.

12.4-2 Duties

The Credentials committees shall:

A. Review and evaluate the qualifications of each practitioner applying for medical staff membership or clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments;

B. Submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions; and

C. Review and report on matters referred by the Chief of Staff regarding the qualifications, conduct, professional character or competence of any applicant or medical staff member.

12.4-3 Meetings

The Credentials Committee shall meet as often as necessary but not less than 10 times per year. The committee shall maintain a record of its proceeding and actions.

12.5 Peer Review Committee

12.5-1 Composition

The Peer Review Committee is composed of five to seven physician medical staff members from several different specialties or departments. Each member serves a term of three years, with a staggering of the terms to provide continuity for the process. The Chief Medical Officer is a permanent, non-voting member of the committee.

12.5-2 Duties

The Peer Review Committee members act as the physician reviewers of the quality of care. Routine review of quality will include ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE). Information reviewed will include specific cases identified through the quality monitoring process or referred by medical and hospital staff; quality indicator data collected on care provided; and patient satisfaction information. In making its determinations, the committee will utilize a number of resources, including, but not limited to, the clinical judgment of the members, input from department chairs, opinions from specialists on or outside the medical staff, and the use of applicable reference material. All determinations of quality of care are made by the committee. The Peer Review Committee reports directly to the Medical Executive Committee and consolidates the quality reporting process for the entire medical staff. All committee reports are confidential, are protected as part of the peer review process, and will be shared only with the Medical Executive Committee. Specific recommendations regarding improvement strategies for any physician will be made to the Medical Executive Committee.

12.5-3 Meetings

The Committee meets at least quarterly and reports to the Medical Executive Committee.

12.6 Other Committees

Such other Medical Staff committees as are deemed appropriate shall be described in the Medical Staff Rules and Regulations.

Article XIII - Meetings

13.1 Meetings

13.1-1 Regular Meetings

Regular meetings of the active medical staff shall be held at least twice a year. The date, place and time of the regular meetings shall be determined by the Medical Education Committee, and adequate notice shall be given to the members.

13.1-2 Special Meetings

Special meetings of the medical staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of ten percent (10%) of the members of the active medical staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within 30 days after receipt of such request. No later than 10 days prior to the meeting, notice shall be mailed or delivered to the members of the staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

13.2 Committee and Department Meetings

13.2-1 Regular Meetings

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

13.2-2 Special Meetings

A special meeting of any medical staff committee or department may be called by the chair thereof, the Medical Executive Committee, or the Chief of Staff, and shall be called by written request of one third of the current members eligible to vote, but not less than two (2) members.

13.3 Quorum

13.3-1 Staff Meetings

The presence of sixty-six percent 66% of the total members of the active medical staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the election or removal of medical staff officers. The presence of thirty-three percent (33%) of such members shall constitute a quorum for all other actions.

13.3-2 Department and Committee Meetings

A quorum of thirty-three percent (33%) of the voting members shall be required for Medical Executive/Credentials Committee and the Peer Review Committee

meetings. For department and other committee meetings, a quorum shall consist of those voting members present (minimum of 2 voting members).

13.4 Manner of Action

Except as otherwise specified, the action of a majority of the members voting at a meeting at which a quorum is present shall be considered the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least a majority of the members entitled to vote. Notice, attendance, and actions including voting and participation may be accomplished by email or other electronic and/or telephonic means where permitted by the chair of the meeting on either an individual or group basis.

13.5 Minutes

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

13.6 Attendance Requirements

13.6-1 Regular Attendance

13.6-1.1 Each member of the active is encouraged to attend Medical Staff meetings.

A. All general Medical Staff meetings duly convened pursuant to these bylaws; and

B. All meetings of each department and committee of which he or she is a member.

13.6-1.2 Attendance at meetings and participation in medical staff activity is expected of all members of the active staff. Actual attendance at meetings shall be reviewed as part of Ongoing Provider Practice Evaluation.

13.6-1.3 Each member of the affiliate staff shall be encouraged to attend such meetings as may be determined by the Medical Executive Committee.

13.6-2 Absence from Meetings

13.6-2.1 Physicians who anticipate (or subsequently discover) that they shall (or were) unable to attend a meeting should notify Medical Staff Services for documentation of an excused absence.

13.6-3 Special Attendance

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least 7 days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting, with respect to which he or she was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action.

13.7 Conduct of Meeting

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

13.8 Executive Session

Executive session is a meeting of the medical staff, or a medical staff committee or department which only voting medical staff committee members may attend, unless others are expressly requested by the membership to attend. Executive session may be called by the presiding officer at the request of any medical staff member, and shall be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

13.9 Permission to Vote

Unless otherwise specified in these bylaws, only members of the Active medical staff may vote in departmental or staff elections, and at committee, department and medical staff meetings.

Article XIV - Confidentiality, Immunity and Releases

14.1 Authorization and Conditions

By applying for or exercising clinical privileges within this hospital, an applicant:

A. Authorizes representatives of the hospital and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

B. Authorizes persons and organizations to provide information concerning such practitioner to the medical staff;

C. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the hospital who acts in accordance with the provisions of this Article; and

D. Acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

14.2 Confidentiality of Information

14.2-1 General

Records and proceedings of all medical staff committees having the responsibility of evaluation and improvement of quality of care rendered in this hospital, including, but not limited to, meetings of the medical staff meeting as a committee of the whole, meetings of departments, meetings of committee established under Article XII, and meetings of special or ad hoc committees created by the Medical Executive Committee (pursuant to Article 12.1) or by departments (pursuant to Article 11.4 I. and L.) and including information regarding any member or applicant to this medical staff shall, to the fullest extent permitted by law, be confidential. Records and proceedings of any medical staff committee may be shared by other/another medical staff committee within Rice Hospital when the information contained in these records is needed to carry out the purposes of the committee.

14.2-2 Breach of Confidentiality

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

14.3 Immunity from Liability

14.3-1 For Action Taken

Each representative of the medical staff and hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised in good faith as a representative of the medical staff or hospital.

14.3-2 For Providing Information

Each representative of the medical staff and hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this hospital.

14.4 Activities and Information Covered

14.4-1 Activities

The confidentiality and immunity provided by this Article shall apply to all good faith acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

A. Application for appointment, reappointment, or clinical privileges;

B Corrective action;

C. Hearings and appellate reviews;

D. Utilization reviews;

E. Other department, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

F. National Practitioner Data Bank queries and reports, peer review organizations, Minnesota Board of Medical Practice and similar reports.

14.5 Releases

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

14.6 Indemnification

The hospital shall defend (or cover the costs incurred for defense), and cover settlements, judgments and damages amounts on behalf of any member of the medical staff serving on or assisting any hospital or medical staff committee, or assisting in peer review or quality management activities involving care provided at the Hospital, involved in claims arising out of such activities, so long as the member of the medical staff acted in good faith.

Article XV - General Provisions

15.1 Rules and Regulations

The medical staff shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its Rules and Regulations to comply with current medical staff practice.

Proposed changes may be originated by the Bylaws Committee, the Medical Executive Committee itself, or by a petition signed by twenty percent (20%) of the active medical staff members. Recommended changes to the Rules and Regulations shall be submitted to the Medical Executive Committee for review and evaluation prior to presentation for consideration by the medical staff as a whole. Each active medical staff member shall be eligible to vote on the changes to the Rules and Regulations via printed or electronic ballot in a manner determined by the Medical Executive Committee. To be adopted, the proposed changes must receive an affirmative vote of fifty-one percent (51%) of those members eligible to vote. An affirmative vote shall be counted by returning the ballot marked “yes” or by not returning the ballot.

In cases of a documented need for an urgent amendment to the rules and regulations necessary to comply with law or regulation, the Medical Executive Committee may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the active medical staff. In such cases, the medical staff will be immediately notified by the Medical Executive Committee of the provisional amendment. The medical staff then has an opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the Medical Executive Committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

Following adoption such Rules and Regulations shall become effective following approval of the Board of Directors, which approval shall not be withheld unreasonably. Applicants and members of the medical staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the bylaws and rules and regulations, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff rules and regulations.

15.2 Dues or Assessments

The Medical Executive Committee shall have the power to determine the amount of annual dues or assessments, if any, for each category of medical staff membership and to determine the manner of expenditure of such funds received.

15.3 Construction of Terms and Headings

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

15.4 Authority to Act

Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

15.5 Division of Fees

Any division of fees by members of the medical staff (except as required by state and federal law) is forbidden and any such division of fees shall be cause for exclusion or expulsion from the medical staff.

15.6 Notices

Except where specific provisions are otherwise provided in these bylaws, any and all notices or demands are required to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Services, first-class postage prepaid with return receipt requested. An alternative delivery mechanism may be used if it is as reliable and expeditious as the U.S. Mail, and if evidence of its use is obtained. Notice to the medical staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of department or committee
Rice Memorial Hospital
301 Becker Ave SW
Willmar MN 56201

Mailed notices to a member, applicant, or other party, shall be to the addressee at the address as it last appears in the official records of the medical staff or the hospital.

15.7 Disclosure of Interest

All nominees for election or appointment to medical staff offices, department chairs, or the Medical Executive Committee shall, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations, or relationships of which they are reasonably aware which could potentially result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

15.8 Medical Staff Credentials Files

15.8-1 Insertion of Adverse Information

The following applies to actions relating to requests for insertion of adverse information into the medical staff member's credentials files;

A. As stated previously, in Article 8.1-1, any person may provide information to the medical staff about the conduct, performance or competence of its members.

B. When a request is made for insertion of adverse information into the medical staff member's credentials file, the respective department chair and Chief of Staff shall review such a request.

C. After such a review a decision shall be made by the respective department chair and Chief of Staff to:

1. Not insert the information;

2. Notify the member of the adverse information by a written summary and offer him/her the opportunity to rebut this assertion before it is entered into his/her file; or

3. Insert the information along with a notation that a request has been made to the Medical Executive Committee for an investigation as outlined in Article 8.1-2 of these bylaws.

D. This decision shall be reported to the Medical Executive Committee. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

15.8-2 Review of Adverse Information at the Time of Reappointment

The following applies to the review of adverse information in the medical staff member's credentials file at the time of reappointment.

A. Prior to recommendation on reappointment, the Credentials Committee, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member.

B. Following this review, the Credentials Committee shall determine whether documentation in the file warrants further action.

C. With respect to such adverse information, if it does not appear that an investigation and/or adverse action on reappointment are warranted, the Credentials Committee shall so inform the Medical Executive Committee.

D. However, if an investigation and/or adverse action on reappointment are warranted, the Credentials Committee shall so inform the Medical Executive Committee.

E. No later than 60 days following final action on reappointment, the Medical Executive Committee shall, except as provided in G.:

1. Initiate a request for corrective action, based on such adverse information and on the Credentials Committee's recommendation relating thereto, or

2. Cause the substance of such adverse information to be summarized and disclosed to the member.

F. The member shall have the right to respond thereto in writing, and the Medical Executive Committee may elect to remove such adverse information on the basis of such response.

G. In the event that adverse information is not utilized as the basis for a request for corrective action, or disclosed to the member as provided herein, it shall be removed from the file and discarded, unless the Medical Executive Committee, by a majority vote, determines that such information is required for continuing evaluation of the member's:

1. Character;

2. Competence; or

3. Professional performance.

15.8-3 Confidentiality

The following applies to records of the medical staff and its committees responsible for the evaluation and improvement of patient care:

A. The records of the medical staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential.

B. Access to such records shall be limited to duly appointed officers and committees of the medical staff for the sole purpose of discharging medical staff responsibilities and subject to the requirement that confidentiality be maintained, except the member may have access to his/her own record as outlined in Article 15.9-3, E. immediately below.

C. Information which is disclosed to the governing body of the hospital or its appointed representatives -- in order that the governing body may discharge its lawful obligations and responsibilities -- shall be maintained by the body as confidential.

D. Information contained in the credentials file of any member may be disclosed with the member's consent, and/or as required by law.

E. A medical staff member shall be granted access to his/her own credentials file, subject to the following provisions:

1. Timely notice of such shall be made by the member to the Chief of Staff or his/her designee;

2. The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information -- including peer review committee findings, letters of reference, monitoring reports, complaints, etc. -- shall be provided to the member, in writing, by the designated officer of the medical staff, at the time the member reviews his/her credentials file. Such summary shall disclose the substance, but not the source, of the information summarized;

3. The review by the member shall take place in the medical staff office, during normal work hours, with an officer or designee of the medical staff present.

15.8-4 Member's Opportunity to Request Correction/Deletion of, and to Make Addition to, Information in File

A. When a member has reviewed his/her file as provided under Article 15.8-3 E. he/she may address to the Chief of Staff a written request for correction or deletion of information in his/her credentials file. Such request shall include a statement of the basis for the action requested.

B. The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, whether or not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

C. The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

D. In any case, a member shall have the right to add to his/her own credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

15.9 Medical Staff Role in Exclusive Contracting

The medical staff shall review and make recommendations to the Board of Directors regarding quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made, in the following situations:

A. The decision to execute an exclusive contract in a previously open department or service;

B. The decision to renew or modify an exclusive contract in a particular department or service;

C. The decision to terminate an exclusive contract in a particular department or service.

15.10 Medical Staff Policy

The Medical Executive Committee shall review, develop and adopt policies which shall be binding upon the medical staff and its members. Such policies must be consistent with the medical staff bylaws and rules and regulations. Only policies adopted by the Medical Executive Committee are binding upon the medical staff and its members.

Article XVI - Adoption and Amendment of Bylaws

16.1 Procedure

16.1-1 Proposed amendments to these bylaws may be originated by the Medical Executive Committee, by the Bylaws Committee after approval by the Medical Executive Committee, or by a petition signed by twenty percent (20%) of the active medical staff members.

16.1-2 Each active medical staff member shall be eligible to vote on the proposed amendment to these bylaws via ballot in a manner determined by the Medical Executive Committee, which may include email or other electronic means.

16.1-3 All active medical staff members shall receive at least thirty (30) days advance notice of the proposed changes.

16.2 Action on Bylaws Change

To be adopted, the proposed changes to these bylaws must receive an affirmative vote of fifty-one percent (51%) of those members eligible to vote. An affirmative vote shall be counted by returning the ballot marked “yes” or by not returning the ballot.

16.3 Approval

Bylaw changes adopted by the medical staff shall become effective following approval by the Board of Directors, which approval shall not be withheld unreasonably. If approval is withheld, the reasons for doing so shall be specified by the Board of Directors in writing, and shall be forwarded to the Chief of Staff and the Medical Executive Committee.

16.4 Exclusivity

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff bylaws.

16.5 Successor in interest

These bylaws, and privileges of individual members of the medical staff accorded under these bylaws, shall be binding upon the medical staff, and the Board of Directors of any successor in interest in this hospital, except where hospital medical staffs are being combined.

ADOPTED by the medical staff on _____

_____
Fred Hund, M.D.
Chief of Staff

_____
Rachel Tollefsrud, M.D.
Secretary - Treasurer

APPROVED by the Board of Directors on _____

_____
Dr. Doug Allen
Chair

_____
Eric Weiberg
Secretary

ADOPTED by the medical staff on 6-6-17

Fred Hund, M.D.
Chief of Staff

Rachel Tollefsrud, M.D.
Secretary - Treasurer

APPROVED by the Board of Directors on 6/21/17

Dr. Doug Allen
Chair

Eric Weiberg
Secretary