Bylaws Medical Staff

Rules and Regulations Medical Staff

TOMAH MEMORIAL HOSPITAL, INC.
d/b/a TOMAH HEALTH Tomah, Wisconsin

Last Revision Date: January 21, 2025

SIGNATURES

Bylaws, Rules and Regulations Revision Approved by Medical Staff on January 13, 2025.

Dr. Tiffany Casper D.O.
Dr. Tiffany Casper D.O. (Jan 14, 2025 12:11 CST)

Jan 14, 2025

Medical Staff President – Tiffany Casper, D.O.

Bylaws, Rules and Regulations Revision Approved by the Board of Directors on January 21, 2025.

Chairperson of the Board - B. Scott Nicol

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DEFINITIONS

Medical Staff, Organized (Medical Staff of the Whole):

A self-governing entity accountable to the governing body that operates under a set of Bylaws, Rules and Regulations, and policies developed and adopted by the voting members of the organized Medical Staff and approved by the governing body. The organized Medical Staff is comprised of physicians (MD and DO), dentists, chiropractors, podiatrists, optometrists and certain Advanced Practice Providers (APPs) including Physician Assistants, Advanced Practice Nurse Practitioners (including those who are Certified Registered Nurse Anesthetists), and Certified Nurse Midwives. These practitioners become Medical Staff members by applying for membership and achieving approval by the Medical Executive Committee ("MEC") and governing body. Allied Health Professional Staff are not included in the organized medical staff, and are defined in Article VI.

Medical Staff, Voting members of the Organized (Active Staff Category of the Medical Staff):

Those practitioners within the organized Medical Staff who have the right to vote on adopting and amending Medical Staff Bylaws, Rules and Regulations, and policies.

BYLAWS

I. NAME

The name of this organization shall be the "Medical Staff of The Hospital."

II. PURPOSE

The purpose of this organization shall be:

A. To support the mission of the Hospital;

B. To review the defined scope of medical services of the Hospital;

C. To promote quality of care for all patients who receive treatment;

D. To make recommendations to the Board of Directors concerning appointments and reappointments to the Medical Staff, including membership category and scope of privileges;

E. To promote a high level of professional performance by all practitioners authorized to practice in the Hospital through an ongoing review and evaluation of each practitioner's performance in the Hospital;

F. To provide a means for managing conflict whereby problems of a medico-administrative nature may be discussed and resolved by the Medical Staff with the Board of Directors and the administration;

G. To provide a framework where by the organized Medical Staff develops and complies with the Medical Staff Bylaws, Rules and Regulations, and policies;

H. To support educational opportunities and to maintain educational standards;

I. To provide administrative procedures for the operation of the Medical Staff of the Hospital.

III. ADOPTION/AMENDMENTS

A. Medical Staff Bylaws

1. The organized Medical Staff adopts and amends Medical Staff Bylaws, upon recommendation of the MEC. Adoption or amendment of Medical Staff Bylaws cannot be delegated. After adoption or amendment by the organized Medical Staff, the

proposed Bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval.

2. Specifically, the process for adoption or amendment shall be as follows, and cannot occur without all of these steps:

   a. Any proposal for adoption or amendment of Medical Staff Bylaws shall first be recommended to the Active Medical Staff by a majority of the MEC.

   b. At least thirty (30) days prior to the Active Staff meeting at which the recommended Bylaws (or amendments) will be considered or alternatively at least thirty (30) days prior to the deadline for electronic voting by the Active Staff, the MEC shall:

      i. Submit a copy of the proposed Bylaws or amendments to the President of the Medical Staff and Chief Executive Officer of the Hospital.

      ii. Provide a copy of the proposed Bylaws or amendments to each member of the Active Staff along with voting deadline notice.

   c. The Active Staff affirmatively approves the proposed Bylaws or amendments by a two-thirds (2/3) majority of the Active Staff. Active Staff must vote in person or by electronic vote at or before 11:59 p.m. on the calendar day of the voting deadline.

   d. The Board of Directors gives final approval to the Bylaws or amendments that have been approved by a two-thirds (2/3) majority of the Active Staff.

B. Rules and Regulations

The Medical Staff shall adopt such Rules and Regulations as may be necessary for the proper conduct of its work, after recommendation by the MEC. Such Rules and Regulations may be adopted or amended by a majority of the Active Medical Staff present at any regular or special meeting of the Active Staff or via electronic vote by the Active Staff. Any proposed adoption or amendment shall be effective when approved by the Board of Directors.

C. Policies

In addition to the Medical Staff Bylaws and Rules and Regulations, there may be Medical Staff policies developed by the Medical Staff. The organized Medical Staff delegates the authority to adopt and amend such policies to the MEC. Such adoption or amendment becomes effective upon a vote of the majority of the MEC at any regular or special meeting or by electronic vote. Any such adoption that requires Board approval or amendment shall be effective upon approval of the Board, and biennial approval of the Board. All other policies (adoption or amendment) become effective upon majority vote by the MEC.

IV. APPOINTMENT

A. Qualifications

1. Applicants for appointment to the Medical Staff shall meet the legal requirements to practice in the State of Wisconsin. Applicants shall be able to document their background, experience, training and demonstrated competence with sufficient adequacy to assure the Medical Staff and the Board of Directors, at appointment or reappointment time, or when a question arises, that any patient treated by them will be given quality medical care.

2. All Medical Staff members must be certified (if applicable) by the appropriate medical board or other certifying agency, or become certified within the first three (3) years following initial appointment. If the Medical Staff member does not have a certification (or board certification) option, this requirement will not apply.

3. Under no circumstance is race, color, sex, sexual orientation, gender identity, religion, national origin, disability, or status as a protected veteran used in determining clinical privileges or appointment to the Medical Staff of the Hospital.

B. Ethics and Ethical Relationships

By applying for membership to the Medical Staff, each member agrees to:

1. Comply with the Code of Ethics, Standards of Behavior, and the Compliance Program of the Hospital.

2. Comply with the Principles of Ethics adopted by the American Medical Association, or parallel principles articulated for practitioners other than physicians.

3. Promptly inform the Hospital of any change in licensure status or other professional status that may affect the member's appointment or privileges.

4. Pledge that the member will not give to or receive from any other provider for referring (or otherwise inducing) patients for care that is not personally rendered by the member, subject to the exceptions specified in Wisconsin law. Medical Staff members will identify and disclose any conflicts of interest that would prevent them from acting in the best interest of the Hospital and its patients, and will not use their medical staff status for personal advantage.

5. If, for religious or moral reasons, a practitioner involved with the care of the patient is unwilling to perform a pertinent procedure or provide pertinent medical intervention that may otherwise be done at this facility, the practitioner shall be responsible to consult with another credentialed practitioner willing to provide that service and facilitate appropriate coverage for the care of the patient.

C. Applications

1. Applications for appointment to the Medical Staff shall be submitted on forms prescribed by Administration or the designated credentialing service. A positive identification of the applicant shall be a part of the application process. The Hospital reserves the right to charge a fee for appointment and reappointment applications. The application shall be considered complete when the applicant provides:

   a. Detailed information concerning the applicant's professional qualifications including the names of all hospitals at which the applicant has previously held privileges, the names of three (3) qualified peer references for initial appointment who have observed and worked extensively with the applicant and who can provide adequate insight pertaining to the applicant's professional competence and ethical character;

   b. Information as to whether the applicant's medical staff appointment or clinical privileges have ever been revoked, suspended, reduced, not renewed, or voluntarily relinquished at any hospital or health care facility, and whether there is any pending action affecting medical staff membership or privileges at another hospital;

   c. Information as to whether the applicant's membership in health care societies has ever been terminated; whether his or her license to practice in any state, or his or her narcotic license has ever been suspended or terminated; whether there is any pending challenge to health care licensure in any state; or whether there is any previously successful or currently pending

challenges to any other health care licensure or registration or the voluntary relinquishment of such licensure or registration. The submitted application shall include primary source verification of the applicant's current license to practice and primary source verification of the current narcotics license if applicable;

d. Information as to whether the applicant currently has in force professional liability insurance coverage in amounts in accordance with current Wisconsin laws;

e. Information concerning the applicant's malpractice experience, including all malpractice judgments or settlements entered or pending against the applicant, all malpractice actions and patient compensation panel actions brought against the applicant, a statement as to whether the applicant's malpractice insurance has ever been cancelled, voluntarily or involuntarily, or not renewed and the reasons therefore;

f. A consent to the release of information from any third party who may have information bearing on any matter relevant to qualifications for appointment. In the event the third party may fail or refuse to provide information concerning the applicant, the applicant shall be responsible for assuring that such information is provided;

g. A request for the clinical privileges desired by the applicant;

h. The applicant's specific acknowledgement of his or her obligation upon appointment to the Medical Staff to provide for continuous care to all patients within the Hospital for whom he or she has responsibility;

i. Specific acknowledgement and acceptance of release and immunity from civil liability provisions in the Medical Staff Bylaws;

j. Information regarding the physical, mental and/or emotional stability of the applicant. It is a prerogative of the Medical Staff to have a physical and/or mental health evaluation performed by a practitioner of its choice; and

k. Such other information as the Medical Staff, Board of Directors or government agencies may require.

2. The application shall be submitted to Administration for the Credentials Committee to review. The Chairman of the Credentials Committee shall arrange for the collection of any additional references and other applicable material as may be needed.

3. Any applicant for appointment or candidate for reappointment agrees to appear before and be interviewed by the appropriate committees. The applicant also authorizes the Hospital and its appropriate representatives to consult with any and all persons or organizations who may have information bearing on his or her competence, health status, character, or ethical qualifications and to inspect any and all records as may be material to an evaluation of his or her qualifications and competence to hold medical staff membership and to carry out the privileges he or she requests. The applicant agrees to release and hold harmless any and all persons or organizations that in good faith provide information to the Hospital bearing on his or her qualifications, competence, health status, character or ethics.

4. The burden of producing all of the information set forth in this Article or otherwise necessary to properly evaluate an application shall be on the applicant. Any falsification or omission of information on an application will stop the credentialing process until such time that the information is accurate and complete. The issue will not be eligible for a fair hearing process. Action on an individual's application for appointment or reappointment is withheld until the information is available and verified.

5. Authorization may be granted, according to the policy established, to those with responsibilities necessary to sustain the functions of this document, while upholding confidentiality, to review a file of a member of the Medical Staff.

D. Terms of Appointment

1. Appointment shall be made by the Board of Directors of the Hospital after recommendation of the MEC and shall be for a period not to exceed three (3) years. The Board of Directors of the Hospital will evaluate and make a determination regarding reappointment of the applicants to the Medical Staff for successive periods of three (3) years on the recommendation of the MEC.

2. All initial appointments for all classifications shall be integrated into the Focused Professional Practice Evaluation process as specified in policy. The appointee shall have the full rights and responsibilities of membership for his or her category of membership.

3. In no case shall the Board of Directors take action on an application, refuse an appointment, or cancel an appointment previously made without receiving a prior written recommendation of the MEC.

E. Procedure for Appointment and Reappointment

1. Application for appointment and reappointment to the Medical Staff shall be presented on the prescribed form which shall state the qualifications and references of an applicant and shall also signify the applicant's agreement to be bound and protected by the Bylaws and Rules and Regulations of the Medical Staff. The application for appointment to the Medical Staff shall be presented to the Chief Executive Officer or designee of the Hospital who shall submit it to the Credentials Committee. This Hospital reserves the right to use a qualified independent centralized credentialing agency to perform credentialing and provide documentation services.

2. The Credentials Committee shall investigate the character, current competence, qualifications and standing of the applicant, as verified from the primary source wherever feasible, including but not limited to, candidate's current licensure, health status, professional performance, judgment, and skills, including the results of ongoing performance improvement activities, peer recommendation(s), meeting attendance records (for reappointment) and continuing education, previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration, the voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital, a criminal background check, a National Practitioner Data Bank query, and an Office of Inspector General query. It is a prerogative of the Medical Staff to request that the applicant have a physical and/or mental health evaluation performed by a practitioner of its choice. The Credentials Committee shall submit a report of findings to the MEC as soon as possible, and in all cases within four (4) months shall recommend that the application be accepted, deferred or rejected. All proposed recommendations for initial appointments and reappointments shall be submitted by the Credentials Committee to the MEC for approval at a regular or special MEC meeting. When a recommendation to defer is made, it must be followed by one to accept or reject the applicant at the next regular meeting of the MEC. Any recommendation for appointment should include a delineation of privileges. An appointment decision shall be made after all credential information is received, verified and reviewed.

The report and completed application shall be kept on file in the administration office.

3. On receipt of the report of the Credentials Committee, the MEC shall recommend to the Board of Directors that the application be accepted, deferred, or rejected, and if accepted, the privileges to be granted.

4. The recommendation of the MEC shall be transmitted to the Board of Directors of the Hospital through the President of the Medical Staff or any appointed designee.

5. Within thirty (30) days the Board of Directors shall accept, reject, or refer back the recommendation of the Medical Staff for further consideration stating the reasons for such action.

6. When final action has been taken by the Board of Directors, the Chief Executive Officer or designee of the Hospital shall be authorized to transmit this decision to the candidate.

7. Expedited credentialing is provided when criteria are met according to the established policy. Information is received and reviewed by the Chief Executive Officer or his or her designee to determine whether the application is appropriate for expedited credentialing in accordance with the requirements of the policy. An application that is eligible for expedited credentialing shall be reviewed by at least two (2) members of the Credentials Committee, three (3) members of the MEC, one (1) of which shall not be a current Credentials Committee member, and three (3) members of the Executive Committee of the Board of Directors.

8. The Credentials Committee representatives shall make recommendations to the MEC representatives. After reviewing the recommendation of the Credentials Committee and the application materials, the MEC representatives shall then make its recommendation to the representatives of the Board of Directors. The representatives of the Board of Directors members shall accept, reject, modify, or refer back the recommendation of the Medical Staff for further consideration stating the reasons for such action. If any adverse recommendation or action made by the MEC or the Board of Directors triggers hearing rights in accordance with the Fair Hearing Plan, the application shall be afforded such rights in accordance with Article XII.

F. Reinstatement to the Medical Staff

1. A practitioner who had previously relinquished their membership and privileges voluntarily may request to be reinstated without having to reapply for initial appointment. The practitioner must be within their original three-year reappointment period. Reinstatement may be requested by submitting a request to the Credentials Committee, along with the documentation outlined in the Hospital's credentialing policy.

G. Appeals

In any case where there is an adverse change in a practitioner's clinical privileges, medical staff appointment or reappointment, the individual shall be entitled to the appeal procedure in Article XII of these Bylaws. The conduct and procedures governing all parties in any case of appeal are outlined in Article XII.

H. Emergency and Temporary Privileges

1. In case of imminent danger to health or in the case of a disaster situation, the practitioner attending the patient shall be expected to do all in his/her power to save the life of the patient, including calling any duly licensed practitioner, not necessarily a member of the staff, for consultation when needed. For the purposes of this Section an emergency is defined as a condition in which the patient faces significant morbidity or the life of the patient is in immediate danger and in which any delay in administering treatment would increase the danger.

2. The Chief Executive Officer of the Hospital, or his/her designee, after conferring with the President of the Medical Staff, shall have the authority to grant temporary privileges as defined in policy to a practitioner who is not a member of the Medical Staff. All temporary staff privileges may be granted for a maximum of up to one hundred twenty (120) days unless a request for privileges is submitted and in process and a patient care need that is identified continues to exist. The President of the Medical Staff shall give an authoritative opinion as to the competence and ethical standing of the practitioner who desires such temporary privileges. In the exercise of such privileges, all temporary staff shall be under direct supervision of the President of the Medical Staff.

3. In case of a disaster situation, practitioners who are not members of the Medical Staff at the Hospital and who do not possess medical staff privileges at this facility may practice at the Hospital during a disaster situation with the status terminating at the end of the

same disaster situation. A disaster situation is defined as any officially declared emergency, whether it is local, state or national. The process to manage performance shall be defined in policy.

I. Telemedicine

Any practitioner who provides telemedicine services at the Hospital must be granted medical staff appointment and clinical privileges prior to the exercise of any privileges. The process for credentialing and privileging telemedicine practitioners is outlined in the Hospital's Telemedicine Policy.

This process shall comply with applicable state and federal laws, as well as The Joint Commission accreditation standards.

J. Leave of Absence

A credentialed health care provider may request a leave of absence according to policy.

K. Resignations

Resignations from appointment on the Medical Staff shall be submitted to the Chief Executive Officer of the Hospital in letter form, with a copy to the President of the Medical Staff.

L. Collegial Intervention

1. Collegial intervention is the practice of the Hospital and its Medical Staff to encourage the use of progressive steps by Medical Staff leaders and Hospital, beginning with collegial and educational efforts, to address questions relating to an appointee's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the appointee to resolve questions that have been raised.

2. Collegial efforts may include, but are not limited to counseling, sharing of comparative data, monitoring, focused professional practice evaluation, and additional training or education.

3. All collegial intervention efforts by Medical Staff leaders and the Hospital management are part of Hospital's performance improvement and professional and peer review activities.

4. The relevant Medical Staff leader(s) shall determine whether it is appropriate to include documentation of collegial intervention efforts in an appointee's confidential peer review file. If documentation of collegial efforts is included in an appointee's file, the individual will have an opportunity to review it and respond in writing. The

response shall be maintained in that individual's file along with the original documentation.

5. Collegial intervention efforts are encouraged, but are not mandatory, and their use is within the discretion of the Medical Staff leaders.

6. The practitioner affected by this collegial intervention recommendation will be notified of the proposed action.

7. The President of the Medical Staff, in conjunction with the Chief Executive Officer, shall determine whether to direct a matter to be handled through corrective action, or in accordance with a different policy of the Hospital or Medical Staff, or to direct the matter to the MEC for further review and determination.

M. Corrective Action

1. Criteria for Initiation of Investigation

A written request for an investigation of an individual shall be made whenever the Medical Staff President, the Chief Executive Officer, an officer of the Medical Staff, a member of the MEC, or a majority of the Board of Directors has cause to question any of the following with respect to any individual with medical staff membership or clinical privileges:

a. Clinical competence;

b. Care or treatment of a patient or patients, or management of a case;

c. Known or suspected violation of the Bylaws or policies of the Hospital, or the Medical Staff Bylaws, Rules or Regulations, Hospital policies or state or federal law;

d. Behavior or conduct that fails to comport with the expectations set forth in these Bylaws, Rules or Regulations or Hospital policies or a generalized failure to work cooperatively and harmoniously with others or with patients, whether or not such behavior or conduct directly affects patient care; or

e. Practitioner impairment as defined in Medical Staff policy.

2. Requests, Investigation, and Report

a. Requests for Corrective Action. All requests for investigation or corrective action shall be in writing, submitted to the MEC

and supported by reference to the specific conduct or activities which constitute the grounds for the request. The Medical Staff President shall promptly notify the Chief Executive Officer of all requests for corrective action received by the Medical Staff and shall continue to keep the Chief Executive Officer fully informed of all action taken in connection therewith. Initiation of corrective action does not preclude a decision to implement summary suspension, nor does initiation of corrective action require such a suspension.

b. The MEC shall meet as soon after receiving the request as practicable and shall determine whether (i) it does not have merit and dismiss the request; (ii) the request for investigation contains information sufficient to warrant a recommendation for action to the Board of Directors; (iii) to immediately commence an investigation of the matter, in accordance with the procedures outlined below; or (iv) to handle the matter by collegial intervention or in accordance with another Hospital or Medical Staff policy or procedure.

c. Investigation

i. If the MEC determines that additional information is required, the MEC shall initiate an investigation of the matter. The investigation shall be performed either by the MEC or by an investigating committee appointed by the MEC.

ii. The group performing the investigation shall have available the full resources of the Medical Staff and the Hospital to aid in its work, as well as the authority to use outside consultants as necessary. The investigating group may also require a physical and/or mental examination of the individual by a practitioner satisfactory to the group and shall require the individual to sign any authorization necessary to ensure that the results are made available for consideration by the group, the MEC, the Board and their representatives.

iii. The individual who is under investigation shall have an opportunity to meet with the investigating group before it makes its report to the MEC. At this meeting, the individual shall be informed of the general nature of the evidence prompting the investigation.

iv. In its discretion, the investigating group may inform the individual about the investigation proceedings prior to the meeting. This interview shall not constitute a hearing, and none of the procedural rules provided in the Bylaws with respect to hearings shall apply.

v. At the conclusion of the investigation, the investigating group shall forward a written report of the investigation to the MEC including, as relevant: (i) a reference to documents reviewed; (ii) a summary of any interview with the individual under investigation; (iii) a summary of any other interviews conducted; (iv) factual findings and conclusions regarding the individual's conduct or competence; (v) a recommendation regarding corrective action; and (vi) a discussion of any other issues or matters relevant to the investigation.

vi. The investigating group shall make a reasonable effort to complete the investigation and forward its report to the MEC within thirty (30) days of the initiation of the investigation. This timeframe is intended to serve as a guideline, and as such, shall not be deemed to create any right for an appointee to have an investigation completed within this time period.

vii. At any time during the investigation, a summary suspension may be invoked, at the MEC's discretion per Article IV, Section N.

3. Recommendations and Actions of the MEC

a. MEC Action. Following receipt of the investigation group's report, the MEC shall take action upon the request. The affected individual shall be permitted to make an appearance before the MEC prior to its taking such action. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A record of such appearance shall be made by the MEC.

b. The MEC shall make reasonable efforts to take such action on a request for corrective action within thirty (30) days of the receipt of the investigation report. Such action may include, without limitation, any one (1) or more of the

following recommendations:

i. Rejecting the request for corrective action;

ii. Issuing a verbal warning, a letter of admonition, or a letter of reprimand;

iii. Performance monitoring;

iv. Medical and/or behavioral health treatment;

v. Terms of probation or requirements of consultation;

vi. Reduction, suspension or revocation of clinical privileges;

vii. Reduction of staff category or limitation of any staff prerogatives;

viii. Suspension or revocation of staff appointment; or

ix. Such other recommendations as it deems appropriate.

In addition, at any time during the investigation, a summary suspension may be invoked at the MEC's discretion. See Article IV, Section N regarding Summary Suspensions.

c. Effect of the Executive Committee Action

i. If the MEC recommends or takes any action that would entitle the individual to hearing rights in accordance with Article XII (the Fair Hearing Plan), the individual in question shall be provided with a notice of such hearing rights in accordance with the requirements for notice outlined in Article XII.

ii. If the recommendation or action of the MEC does not entitle the individual to hearing rights under the Fair Hearing Plan, the action shall take effect immediately and a report of the action taken and the reasons therefor shall be made to the Board through the Chief Executive Officer and the action shall stand unless modified by the Board of Directors.

4. Recommendations and Actions by the Board of Directors

a. If the recommendation or action by the MEC does not

constitute an adverse action as determined by Article XII, the recommendation shall take effect immediately without action of the Board of Directors and without the right of appeal to the Board of Directors. In this case, a report of the recommendation and of the reasons therefor shall be made to the Board of Directors through the Chief Executive Officer and the recommendation shall stand unless modified by the Board of Directors. In such a circumstance, should the Board of Directors determine to consider modification of the recommendation of the MEC in a manner considered to be an adverse action under Article XII, the Board of Directors shall give notice of this determination to the individual under investigation, through the Chief Executive Officer, and the Board of Directors shall take no final action until the individual has exercised or has been deemed to have waived the procedural rights provided in Article XII of these Bylaws.

N. Summary Suspension

1. Grounds for Summary Suspension or Restriction:

a. The Chief Executive Officer, Medical Staff President, a member of the MEC, or a majority of the Board of Directors shall each have the authority to summarily suspend or restrict all or any portion of an individual's clinical privileges whenever he or she determines that failure to take immediate action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital.

b. A summary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrences that raises concern, following a pattern of occurrences that raises concerns, or following a recommendation of the MEC that would entitle the individual to request a hearing.

c. Summary suspension or restriction shall become effective immediately upon its imposition, shall immediately be reported in writing to the Chief Executive Officer and the Medical Staff President, and shall remain in effect unless or until it is modified by the MEC or Board of Directors.

d. Notice of such suspension or restriction shall be delivered by either (1) certified mail, return receipt requested, to the

practitioner's last known residential or office address, or (2) personal delivery to the practitioner. The notice shall state the reasons for the imposition of the summary suspension or restriction.

e. Immediately upon the imposition of a summary suspension or restriction, the Medical Staff President shall have authority and discretion to provide for alternative medical coverage for the patients of the suspended (or otherwise restricted) practitioner still in the Hospital at the time of such suspension or restriction.

f. The wishes of the patients shall be considered in the selection of such alternative practitioner.

2. MEC Procedure

a. As soon as reasonably possible after the summary suspension or restriction is imposed, but in no event more than fourteen (14) days after imposition of such summary suspension or restriction, the MEC shall meet to review and consider the summary suspension or restriction. The MEC shall invite the affected individual to discuss the matter at this meeting, although the meeting shall not constitute a formal hearing, the individual shall not be entitled to have an attorney present, and the individual shall be dismissed prior to deliberations. The MEC may recommend a modification or continuation of the suspension or restriction, or it may terminate the suspension or restriction. The MEC should also determine whether it is necessary to initiate the corrective action process outlined in Article IV, Section L.

b. Any procedural rights the individual may have in connection with the summary suspension or restriction as sustained or modified by the MEC shall remain in effect pending a final recommendation to and a decision by the Board of Directors. The affected individual shall not be entitled to a hearing based on the imposition of a summary suspension or restriction that lasts for fourteen (14) or fewer days. However, a summary suspension that stays in effect for longer than fourteen (14) days shall entitle the individual to procedural rights provided in Article XII, including the right to request a hearing. If a simultaneous corrective action process also results in a right to hearing, the affected individual shall be entitled to only one (1) hearing on suspensions or adverse recommendations resulting from the same issues or conduct. Unless reinstated by the MEC or the Board of Directors, any

restriction of privileges will remain in effect during the hearing process.

O. Automatic Suspension

1. Whenever a practitioner's license, certificate, or other legal credential authorizing practice in this state is revoked or restricted, staff membership and clinical privileges for specified services shall be automatically revoked or accordingly restricted.

2. Whenever a practitioner's license, certificate, or other legal credential is suspended, staff membership and clinical privilege shall be automatically suspended effective on the terms of the suspension.

3. A practitioner whose Drug Enforcement Administration (DEA) number is revoked, suspended or voluntarily relinquished shall immediately and automatically be divested of the right to prescribe medications covered by such number.

4. As soon as reasonably possible after such automatic suspension, the MEC shall convene to review and consider the facts. The MEC may then take such further action as is appropriate to the facts disclosed in its investigation.

5. Upon exhaustion of appeals after conviction of a felony of a practitioner in any federal or state court, the appointment is automatically revoked. Practitioner's revocation pursuant to this Section of the Bylaws does not preclude the staff member from subsequently reapplying for appointment. The filing of criminal charges or a finding of guilty by a court of record may constitute sufficient basis for involving some type of corrective action.

6. Such revocation or suspension shall remain in effect until the matter is resolved, and said resolution is acted upon by the MEC. In no case shall the action of the MEC exceed forty-five (45) days after receipt of documentation.

P. Reportable Actions

The Hospital will comply with regulatory reporting requirements as a result of any actions taken.

V. CATEGORIES OF THE MEDICAL STAFF

A. The Medical Staff

The Medical Staff shall be divided into honorary, active staff, consulting staff, courtesy staff and telemedicine staff categories. A majority of the Medical Staff will consist of physicians, in accordance with accreditation requirements. Members will exercise only those inpatient or outpatient clinical privileges that are granted by the Board, in accordance with Article VII.

B. The Honorary Medical Staff

1. The honorary medical staff shall consist of MD/DOs, dentists, podiatrists, optometrists and chiropractors who are not active in the hospital and who are honored by emeritus positions. These may be (1) MD/DOs, dentists, podiatrists, optometrists and chiropractors who have retired from active hospital services; or (2) MD/DOs, dentists, podiatrists, optometrists and chiropractors of outstanding reputation not necessarily a resident in the community. The honorary staff will be appointed by the Board of Directors of the hospital upon the recommendation of the medical staff.

2. The honorary medical staff is not eligible to attend meetings, vote or hold office, does not admit patients and shall have no assigned duties.

C. Active Medical Staff

The Active Medical Staff shall consist of those members who:

1. Regularly admit patients or regularly treat outpatients of the Hospital or are otherwise regularly involved in the care of patients of the Hospital;

2. Meet the qualifications for medical staff appointment, reappointment and continued membership specified anywhere in these Bylaws or other governing documents; and

3. Accept the responsibilities of membership on the Active Medical Staff.

4. Active Staff Members may:

   a. Admit patients as inpatients or see patients as outpatients without numerical limitation;

   b. Exercise such clinical privileges as are granted by the Board of Directors;

   c. Attend general and special meetings of the Medical Staff and

vote on all matters presented at such meetings;

d. Serve on Medical Staff committees as appropriate and vote on matters presented at such meetings; and

e. Attend educational programs of the Medical Staff and Hospital.

5. Active Staff Members must:

a. Fulfill the basic obligations and responsibilities set forth in these Bylaws;

b. Retain responsibility within the area of professional competence for the continuous care and supervision of each patient of the Hospital for whom the member is providing services, or ensure a suitable alternative for such care and supervision;

c. Actively participate (absent extenuating circumstances or MEC approval) in recognized functions of the Medical Staff, including but not limited to quality/performance improvement, peer review, and monitoring activities including the Hospital's ongoing and focused professional practice evaluations, and ensure that the Medical Staff has sufficient information to conduct such activities;

d. Accept consultations when requested;

e. Attend Medical Staff meetings and council meetings to which they have been appointed;

f. If the member is a physician, participate in call and the Hospital's Emergency Service Care Assignment process and care for unassigned patients, absent extenuating circumstances or MEC approval.

D. Consulting Staff

1. The Consulting Staff shall consist of those members who are eligible for medical staff appointment but who wish to care for patients on a consultation basis only, each of whom:

a. Meets the qualifications for medical staff appointment, reappointment and continued membership specified anywhere in these Bylaws or other governing documents;

b. Has the requisite experience and training in the area of

specialty for which the member is consulted; and

c. Accepts the responsibilities of membership on the Consulting Staff.

2. Consulting Staff Members may:

a. Exercise such clinical privileges as are granted by the Board of Directors;

b. Attend general and special meetings of the Medical Staff without vote and serve on committees, without vote; and

c. Attend educational programs of the Medical Staff and Hospital.

3. Consulting Staff Members must:

a. Fulfill the basic responsibilities and obligations set forth in these Bylaws and other governing documents;

b. Retain responsibility within the area of professional competence for the continuous care and supervision of each patient of the Hospital for whom the member is providing services, or ensure a suitable alternative for such care and supervision;

c. Cooperate with recognized functions of the Medical Staff, including but not limited to: quality/performance improvement, peer review, and monitoring activities including the Hospital's ongoing and focused professional practice evaluations, and ensure that the Medical Staff has sufficient information to conduct such activities;

d. Attend committee meetings (with vote) where the members have been appointed to such committee; and

e. Consulting Staff are not required to participate in emergency call.

E. Telemedicine Staff

1. The Telemedicine Staff shall consist of those members who are qualified for medical staff appointment but provide services in the Hospital only through a telemedicine link.

2. Telemedicine Staff Members may:

a. Care for patients at the Hospital via telemedicine link;

b. Exercise such clinical privileges as are granted by the Board of Directors, upon recommendation of the MEC;

c. Attend Medical Staff general and special meetings without vote;

d. Be appointed to committees (with vote) and engage in special projects at the request of the MEC; and

e. Attend educational programs of the Medical Staff and Hospital.

3. Telemedicine Staff Members must:

a. Fulfill the basic responsibilities and obligations set forth in these Bylaws and other applicable governing documents and policies;

b. Retain responsibility within the area of professional competence for the continuous care and supervision of each patient in the Hospital for whom the member is providing services, or ensure a suitable alternative for such care and supervision;

c. Cooperate with recognized functions of the Medical Staff including, but not limited to quality/performance improvement, peer review, and monitoring activities including the Hospital's ongoing and focused professional practice evaluations, and ensure that the Medical Staff has sufficient information to conduct such activities; and

d. Attend committee meetings to which they have been appointed.

e. Telemedicine Staff are excused from call.

F. Courtesy Staff

1. The Courtesy Staff shall consist of those members who:

a. Continuously meet the qualifications for medical staff appointment, reappointment and continued membership specified anywhere in these Bylaws or other governing documents.

b. Occasionally admit patients or treat outpatients of the

Hospital or are otherwise occasionally involved in the care of patients of the Hospital].

2. Appointees to the Courtesy Staff may:

   a. Exercise such clinical privileges as are granted by the Board upon recommendation of the MEC, potentially including the privilege to admit patients for certain services on a limited basis subject to Hospital capacity;

   b. Attend Medical Staff general and special meetings without vote; and

   c. Be appointed to Medical Staff committees (other than the MEC) or special projects directed by the MEC and vote on matters presented at such committee meetings.

3. Appointees to the Courtesy Staff must:

   a. Assist the Hospital in the fulfillment of its mission and assist the Medical Staff in fulfillment of its obligations under these Bylaws.

   b. Provide each of their Hospital patients with continuous care and supervision at the generally recognized professional level of quality and efficiency.

   c. Abide by the ethical principles of the Medical Staff member's profession, as applicable.

   d. Abide by the Medical Staff Bylaws, Rules and Regulations, and all other Medical Staff and Hospital policies and rules.

VI. ALLIED HEALTH PROFESSIONAL STAFF

A. The allied health professional staff shall consist of clinical psychologists, behavioral health specialists, nurse clinicians, nurse practitioners who are not advanced practice nurse prescribers, midwives other than certified nurse midwives, certified registered nurse anesthetists who are not advanced practice nurse prescribers and occupational therapists, physical therapists, licensed social workers, pharmacists or others holding a license, certificate or other legal credentials as required by state law, who:

   1. Document their experience, background, training, demonstrated ability, physical and mental health status, appropriate professional references, current licensure, current professional liability insurance coverage, and are qualified to provide a needed service within the Hospital;

2. Agree to adhere strictly to the ethics of their professions and to work cooperatively with others;
3. Apply for clinical privileges for specified services in the same manner as outlined in Article IV, Section C; and
4. Allied health professionals are providers who hold clinical privileges but who are not members of the Medical Staff, may not vote or hold office or other prerogatives or obligations of Medical Staff membership, but are entitled to due process proceedings.

B. The clinical duties and responsibilities of allied health professionals shall be based on each individual's training, experience and demonstrated competence as appropriate. The Credentials Committee shall make recommendations regarding the privileging of allied health professionals.

C. Allied health professionals shall:

1. Provide specific patient care services, consistent with the allied health professional's privileges and scope of practice under applicable law, under the level of supervision or collaboration with a physician member of the Medical Staff that is required by law or by the Medical Staff Bylaws or any other governance document or policy.;
2. Record reports and progress notes in each patient's medical record and direct care including issuing orders if allowable by applicable law and privileges;
3. Serve on Medical Staff and Hospital committees as appointed;
4. Attend meetings and education programs of the staff when required;
5. Exercise judgment within their areas of competence and retain appropriate responsibility within their area of professional competence and scope of practice for the care of each patient in the Hospital for whom they are providing services; or arrange a suitable alternative for such care and supervision;
6. Participate in the performance improvement activities required of the Allied Health Professional Staff; and
7. Agree to follow all appropriate Hospital and Medical Staff policies and procedures;

D. Allied Health Professional Corrective Action Process.

1. Triggering Events. The following recommendations or actions

shall, if taken on the basis of the AHP's competence or conduct and if deemed adverse under Article VI.D.2 below, entitle the AHP to a hearing and an appeal, as designated below, if timely and properly requested:

a. Denial or restriction of requested Clinical Privileges;

b. Reduction of Clinical Privileges;

c. Suspension of Clinical Privileges; or

d. Revocation of Clinical Privileges.

2. When Deemed Adverse. A recommendation or action listed in Article VI.D.1 above is adverse only when it relates to the AHP's competence and conduct and has been:

a. Recommended by the MEC to the Board; or

b. Taken by the Board under circumstances in which no prior right to request a hearing and appeal existed.

3. Notice of Adverse Recommendation or Action. The CEO shall promptly give the AHP Special Notice of an adverse recommendation or action taken pursuant to this Section of the Bylaws. The notice shall:

a. Advise the AHP of the recommendation or action and of the AHP's right to request a hearing pursuant to the provisions of this policy;

b. Specify that the AHP has thirty (30) days after receiving the notice within which to submit a request for a hearing;

c. Indicate that the right to the hearing may be forfeited if the AHP fails, without good cause, to appear at the scheduled hearing;

d. State that as part of the hearing, the AHP involved has the right to receive an explanation of the decision made and to submit any additional information the AHP deems relevant to the review and appeal of this decision; and

e. State that upon completion of the hearing, the AHP involved has the right to receive a written report of the Hospital's decision, including a statement of the basis of the decision.

4. Request for Hearing. The AHP has thirty (30) days after receiving notice under Article VI.D.3 to file a request for a hearing. The request must be delivered to the CEO either in person or by certified or registered mail.

5. Waiver by Failure to Request a Hearing. An AHP who fails to request a hearing within the time and in the manner specified in Article VI.D.4 waives the right to a hearing and appeal to which he might otherwise have been entitled. Such waiver applies only to the matters that were the basis for the adverse recommendation or action triggering the notice referenced in Article VI.D.3 above.

6. Hearing Procedure. When an AHP requests a hearing, the hearing shall consist of a single meeting attended by the AHP, the supervising/collaborating Physician, as applicable, the CEO, and the Chief of Staff. During this meeting, the basis of the decision adverse to the AHP, which gave rise to the hearing, will be reviewed with the AHP, and the AHP will have the opportunity to present any additional information the AHP deems relevant to the review of the decision. Following this meeting, the CEO and Chief of Staff will make a recommendation to the MEC or the Board, as appropriate, which will then determine if the adverse decision will stand, be modified, or be reversed. The AHP will receive a written report of the Hospital's decision stating the result of the hearing and the basis of the decision.

7. Request for Appeal. The AHP has thirty (30) days after receiving notice of the result of the hearing under Article VI.D.6 to file a request for an appeal. The request must be delivered to the CEO either in person or by certified or registered mail.

8. Waiver by Failure to Request an Appeal. An AHP who fails to request an appeal within the time and in the manner specified in Article VI.D.8 waives the right to an appeal to which they might otherwise have been entitled. Such waiver applies only to the matters that were the basis for the adverse recommendation or action triggering the notice referenced in Article VI.D.3 above.

9. Appeal Procedure. When an AHP requests an appeal, the appeal shall consist of a single meeting attended by the AHP, the Board chair and two (2) Board members appointed by the Board chair. During this meeting, the basis of the decision adverse to the AHP, which gave rise to the appeal, will be reviewed with the AHP, and he will have the opportunity to present any additional information deemed relevant to the review of the decision. Following this meeting, the Board chair and the other two (2) Board members

hearing the appeal will make a recommendation to the full Board, which will then determine if the adverse decision will stand, be modified, or be reversed. The AHP will receive a written report of the Board's decision stating the result of the appeal and the basis of the decision.

10. Sole Remedy. This hearing and appeal process will be the sole remedy available to an AHP who qualifies for this hearing and appeal process who experiences an adverse decision as defined in Article VI.D.2 above.

11. AHP's Right to Legal Counsel. Nothing in this policy shall be deemed to deny an AHP the right to engage or be advised by legal counsel. However, participation by legal counsel at the hearing or appeal meeting shall be at the sole discretion of the Hospital.

VII. DETERMINATION OF QUALIFICATIONS AND PRIVILEGES

A. Classification of Privileges

1. Every practitioner caring for patients at the Hospital, by virtue of medical or allied health professional staff membership, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to them by the Board of Directors, except as provided in Article IV, Section G.

2. Privileges granted to the organized medical staff shall be based on their training, experience, and demonstrated competence and judgment. Surgical procedures performed by a dentist and podiatrist shall be under the overall supervision of the medical director of surgery and anesthesia. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. An MD/DO 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.

B. Ongoing and Focused Professional Practice Evaluation

1. Every initial application for staff appointment must contain a request for Hospital specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated current competence, peer recommendation and other relevant information. The applicant shall have the burden of establishing qualifications and competency in the clinical privileges requested.

2. The medical staff appointees must be in compliance with the State of Wisconsin Medical Examining Board's requirements on continuing medical education.

3. Periodic redetermination of clinical privileges and the increase or curtailment of privileges shall be based upon the direct observation of care provided, review of the records of patients, peer review, and review of the records of the Medical Staff which document the evaluation of the members' participation in medical care and review of ongoing performance improvement activities. Applications for additional clinical privileges must be in writing and shall state which clinical privilege is desired and the applicant's relevant recent training and/or experience. Such applications will be processed in the same manner as applications for initial appointment. Specific processes for Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation shall be used and are defined in policy.

4. Privileges granted to dentists and podiatrists shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical privileges that each dentist and podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentist and podiatrist shall be under the overall supervision of the director of surgery and anesthesia. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. An MD/DO 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.

VIII. OFFICERS

A. Officers

1. The officers of the Medical Staff shall be the President, Vice-President and the Secretary. The officers shall be elected by a majority vote of the members of the MEC immediately following the annual meeting of the Medical Staff for a term of (2) two years. If the President should vacate office for any reason, prior to the end of the elected term, the Vice-President becomes the President. If the Vice-President or Secretary vacates office, the term will be filled with a member of the existing MEC by majority vote of the remaining members of the MEC.

2. Officers of the Medical Staff must be physician members of the Active Staff.

3. The President of the Medical Staff shall serve as the Chief Administrative Officer of the Medical Staff. The President shall have demonstrated ability in leadership, administration, professional relations and decision-making. The President's duties shall include the following:

    a. Serve as presiding officer at MEC meetings and meetings of the Medical Staff;

    b. Serve as a member as requested on any Medical Staff committees;

    c. Appoint Medical Staff committee members and department liaisons;

    d. Enforce Medical Staff Bylaws, Rules and Regulations and policies;

    e. Serve as an ex-officio member of the Board of Directors with vote;

    f. Present the views, policies, needs and grievances of the Medical Staff to the Chief Executive Officer of the Hospital and the Board of Directors;

    g. Serve as a responsible representative of the Medical Staff to receive and interpret policies from the Board of Directors and to report on and interpret to the Board of Directors the performance and maintenance of the Medical Staff's responsibility for providing quality medical care;

    h. Act as Medical Staff spokesperson for the Medical Staff's external, professional and public relations; and

    i. Be responsible for supporting educational opportunities and maintaining educational standards.

4. The Vice-President, in the absence of the President, shall assume all duties and authority of the President. The Vice-President shall be expected to perform such duties as may be assigned by the President.

5. The Secretary, in the absence of the President and Vice-President, shall assume all duties and authority of the President. The

Secretary shall be expected to perform such duties as may be assigned by the President.

6. The Secretary shall be responsible for the recording of complete minutes of all the meetings, call meetings on order of the President, attend to all correspondence and perform such duties that ordinarily pertain to the office. The Secretary shall keep records of attendance at Medical Staff meetings.

7. Removal of a Medical Staff officer during his or her term of office may be initiated by a two-thirds (2/3) majority vote of all active staff members. Such action is to be based on an inability or failure to perform the duties or responsibilities of the office or failure to retain the qualifications for the position and/or conduct not consistent with professional standards of the Bylaws. Removal from elected office shall not entitle the Medical Staff officer to the fair hearing process.

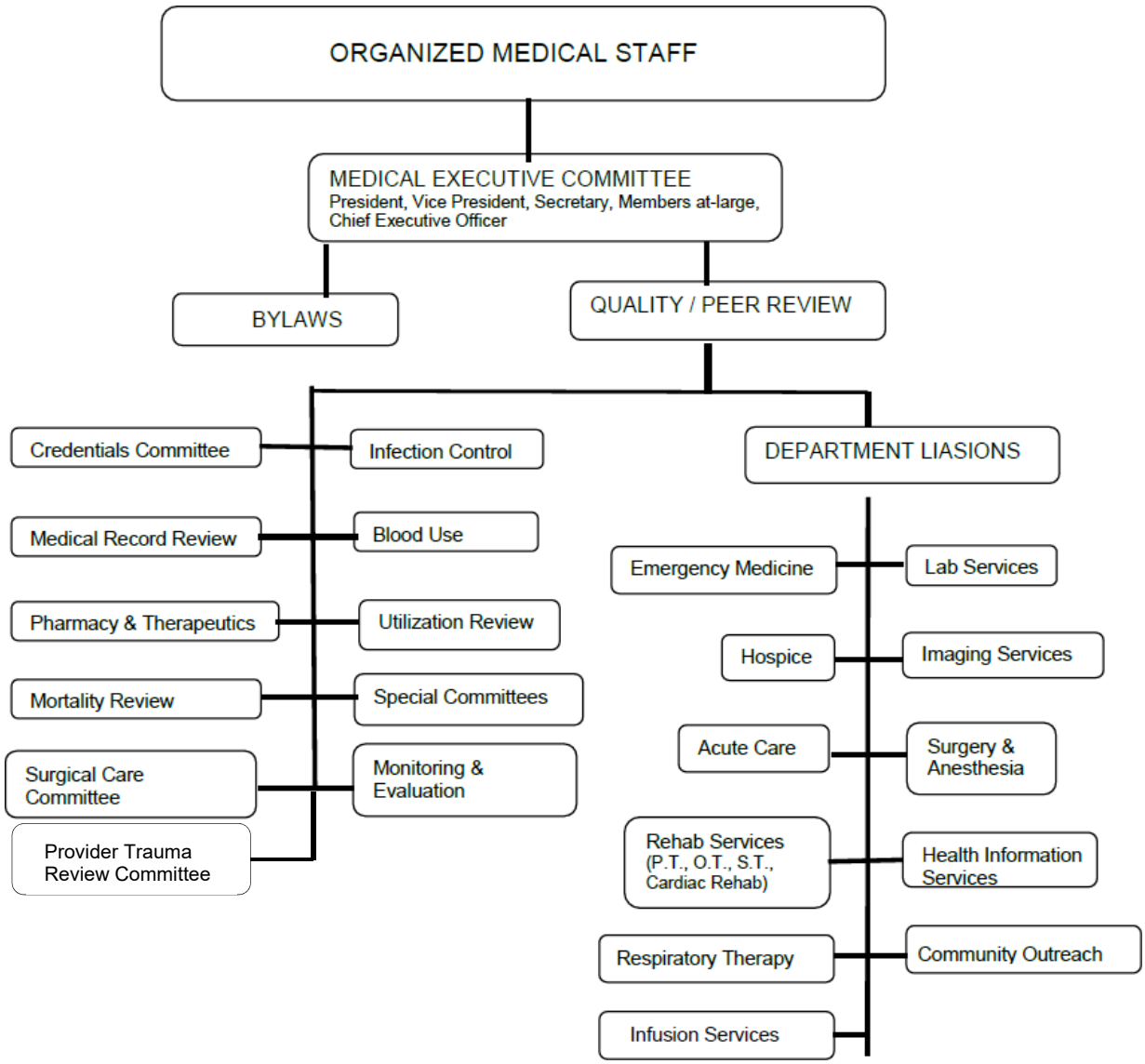
IX. MEDICAL STAFF COMMITTEES AND FUNCTIONS

A. Records. The Medical Staff Executive Committee and all committees/functions shall keep records of their proceedings and shall assume responsibility for complying with the Hospital's Performance Improvement Plan by assuming a leadership role in the measurement, assessment and improvement of clinical improvement processes.

B. Organizational Chart. All Medical Staff committees shall record minutes from their meetings. *(See the following page for chart.)*

C. Quorum. Each committee/function is responsible for determining its composition and voting requirements with approval by MEC.

CHART REFLECTING MEDICAL STAFF ORGANIZATION



D. The Medical Executive Committee

1. The MEC shall be comprised of six (6) Active Medical Staff members elected by the Active Medical Staff at an annual meeting, each for a term of two (2) years. The six (6) members of the MEC will include three (3) officers (who must be an MD or DO) and three (3) members at large, with at least one member being a non-physician member. The MEC will fill any vacant at large positions between annual meetings by majority vote of the MEC. The Chief Executive Officer of the Hospital or his/her designee attends each MEC meeting on an ex-officio basis without vote. The MEC has the responsibility for oversight of the Medical Staff and is authorized to act on behalf of the Medical Staff.

2. The MEC shall keep records of their proceedings and shall oversee compliance with the Medical Staff Bylaws and all other related governance documents including but not limited to the Rules and Regulations, the Quality Assurance Performance Improvement Plan, the Emergency Operations Plan, and all other Medical Staff policies and procedures.

3. MEC members may be removed from their position as follows:

   a. The removal procedure for officers of the MEC is specified in Article VIII.A.7 of these Bylaws. Such removal shall not entitle the officer to procedural rights under these Bylaws.

   b. The removal procedure for at large members of the MEC is as follows:

      i. The Active Staff votes to remove the at large member by a two-thirds (2/3) majority of those voting, either at a general or special meeting or by electronic vote.

      ii. The grounds for removing an at large member of the MEC include (but are not limited to):

         (a) Inability or failure to perform the duties or responsibilities of the office;

         (b) Failure to retain the qualifications for the position; and

(c) Conduct that is inconsistent with the expectations set forth in the Medical Staff Bylaws or other governing documents.

c. Removal from elected office shall not entitle the MEC member to the fair hearing process.

4. The duties of the MEC shall be to:

a. Receive and act upon the reports and recommendations of all standing and ad hoc Medical Staff committees;

b. Act upon Medical Staff membership, rules for and termination of membership, privileges and fair hearings;

c. Consider and recommend action to the Chief Executive Officer of the Hospital regarding risk management including legal exposure;

d. Implement the approved policies of the Medical Staff;

e. Make recommendations to the Board of Directors;

f. Take all reasonable steps to ensure professional and ethical conduct on the part of all members of the Medical Staff and to initiate corrective measures as indicated;

g. Oversee the clinical care rendered to the patients in the Hospital;

h. Ensure that the Medical Staff is apprised of the accreditation status of the Hospital;

i. Represent and to act on behalf of the Medical Staff; subject to such limitation as may be imposed by these Bylaws;

j. Maintain the Hospital's Quality Assurance Performance Improvement Plan and report related activities to the Board of Directors by assuming a leadership role in the measurement, assessment and improvement of clinical improvement processes;

k. Adopt and amend Medical Staff policies as necessary; and

l. Review the Medical Staff Bylaws and the Rules and Regulations every two (2) years and recommend revisions to the Medical Staff.

5. The MEC shall meet as often as necessary to discharge its duties, meeting at least ten times per year, on a monthly basis where possible.

6. The MEC will maintain a permanent record of its meetings and actions.

E. Other Standing Committees/Functions

All Quality/Peer Review Committees and functions report to the Medical Staff Executive Committee. Information generated within the scope of quality improvement and peer review shall be identified as such and used for the sole purpose of reviewing or evaluating the quality of care and services of the hospital and the individual health care providers working at the hospital. The investigations, inquiries, proceedings and/or conclusions shall be documented and maintained in a confidential manner in accordance with Wis. Stat. s. 146.38 and other applicable law regarding peer review. All of the below standing committees are established by and report to the MEC. Where appropriate and indicated under applicable law, the record of inquiry for each committee shall be protected as confidential peer review.

1. CREDENTIALS COMMITTEE: The Credentials Committee is responsible for ensuring the qualifications of applicants for clinical privileges or medical staff appointment to the Hospital. The Credentials Committee will gather and review appropriate data and make recommendations regarding privileges, appointment and reappointment to the MEC.

2. MEDICAL RECORD REVIEW FUNCTION: The Medical Record Review function shall include ongoing review to ensure compliance with all legal and accreditation requirements relating to each patient's legal health record, as maintained by the Hospital.

3. PHARMACY AND THERAPEUTICS COMMITTEE: The Pharmacy and Therapeutics Committee shall review drug utilization policies and practices within the Hospital to assure optimal clinical results and minimize risk. This Committee shall establish formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to medications used in the Hospital, in accordance with all applicable regulatory parameters.

4. MORTALITY REVIEW FUNCTION: Hospital mortalities will be reviewed on an ongoing basis to seek opportunities for improvement related to the care and treatment of patients.

5. SURGICAL CARE COMMITTEE: Consistent reviews of operative and other procedures which place patients at potential risk will be made, and suggested measures for improvement will be considered.

6. MONITORING AND EVALUATION FUNCTION: This function is responsible for peer review to ensure standards of care are met, and for determining opportunities for improvement and create processes by which care is improved.

7. INFECTION CONTROL COMMITTEE: The Infection Control Committee is responsible for the surveillance of nosocomial infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards and the supervision of infection control in all phases of the Hospital's activities.

8. BLOOD USE REVIEW FUNCTION: The Blood Use Review function reviews all transfusions of blood or blood derivatives and any significant adverse reactions, and assesses and makes recommendations as necessary, regarding policies and procedural improvements related to the distribution, handling, administration, ordering practices and transfusion services for blood or blood components.

9. UTILIZATION REVIEW COMMITTEE: The Utilization Review Committee shall evaluate the appropriateness of admission to the Hospital, length of stay, discharge practices, use of medical and Hospital services and all related factors which may contribute to the effective and efficient utilization of Hospital and Medical Staff services.

10. PROVIDER TRAUMA REVIEW COMMITTEE: Trauma cases will be reviewed on an ongoing basis to seek opportunities for improvement related to the care and treatment of patients.

11. SPECIAL COMMITTEES: Special Committees may be established by the MEC to carry out specific projects or initiatives of the Medical Staff. These groups shall perform the duties and exercise the authority specifically conferred by the MEC in writing and shall report to the MEC.

F. Department Liaisons:

1. Department liaisons for specific services shall be appointed for two (2) year terms by the President of the Medical Staff with the

concurrence of the Chief Executive Officer of the Hospital.

2. The department liaison will give overall professional direction and provide liaison between Hospital administration and the Medical Staff.

3. Department liaisons shall be appointed for Emergency Medicine, Hospice, Medical/Surgical Unit, Rehab Services (Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehab), Respiratory Therapy, Laboratory, Radiology, Surgery and Anesthesia, Obstetrics and others that may be required.

X. MEETINGS

A. The Annual Meeting

The Annual Meeting shall be held no more than ten (10) business days preceding the Hospital Corporation's annual meeting.

1. The agenda for the Annual Meeting shall include a MEC report on its review of the medical work of the staff during the year.

2. Only the Active Staff may vote at the Annual Meeting.

3. Voting may occur in person, by proxy (provided there is written notice to the President of the Medical Staff in advance of the Annual Meeting).

4. Medical Staff officer terms and MEC terms will begin immediately upon the Board's ratification of the elected officers and MEC members at the Hospital's annual meeting of the Corporation in January.

B. Regular Meetings

The full Medical Staff shall meet no less than three (3) times per year to be apprised of Medical Staff matters and act on any issues requiring vote.

C. Special Meetings

Special meetings of the Medical Staff may be called at any time by the president, by request of the Board of Directors or any four (4) members of the Active Medical Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Sufficient notice of any meeting shall be sent to members of the Medical Staff at least forty-eight (48) hours prior to the meeting.

D. Attendance at Medical Staff Meetings.

1. All Medical Staff members are encouraged to attend all meetings of the Medical Staff and Active Staff members are required to attend at least fifty percent (50%) of the meetings in a given calendar year, unless excused by the Medical Staff President or designee.

2. An Active Staff member's failure to attend meetings as stated herein may result in nonrenewal of privileges or appointment without right to hearing or procedural rights. Application for reinstatement (in the event of nonrenewal on this basis) may be made to the MEC.

3. Medical Staff members in categories other than the Active Staff may attend, but are not required to attend, Medical Staff meetings.

E. Attendance at MEC Meetings.

1. All MEC members are expected to attend all MEC meetings unless excused by the President of the Medical Staff.

2. MEC members must, unless excused by the President of the Medical Staff, attend a minimum of seventy-five percent (75%) each calendar year. Failure to comply may be a basis for removal from the MEC.

F. Quorum at Medical Staff Meetings

For meetings of the entire Medical Staff, a quorum is established by those members of the Active Medical Staff who are present at the meeting.

G. Quorum at MEC Meetings

A quorum for the MEC shall be four (4) members.

XI. IMMUNITY FROM LIABILITY

A. All practitioner applications for, or exercise of clinical privileges at the Hospital shall be subject to the following conditions:

1. No designated representative of the Hospital as defined in Article XI.A.2. shall be held liable in any judicial proceeding for damages or any other relief for any action, communication, report, recommendation, or disclosure with respect to any practitioner, performed or made in good faith and without malice and at the request of this Hospital or for any other health care facility, for the purpose of achieving and maintaining quality patient care in this Hospital or any other health care facility and shall be privileged to the fullest extent permitted by law.

2. Such immunity shall extend to the Hospital's Medical Staff organization and any member, officer or committee thereof; the Hospital's Board of Directors and any member, officer or committee thereof; the Chief Executive Officer of the Hospital; and any individual authorized by any of the foregoing, to include a contract credentialing agency, to perform specific information gathering or disseminating functions; and to third parties, who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from whom information has been requested by authorized representatives of the Board of Directors, Medical Staff or Chief Executive Officer of the Hospital.

3. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure.

4. That immunity shall apply to all acts, communications, reports, recommendation, or disclosures performed or made in connection with this or any other health care institution's activities related but not limited to:

   a. Applications for appointment or clinical privileges;

   b. Periodic reappraisals for reappointment or for increase or decrease in clinical privileges;

   c. Proceedings for suspensions, hearings or appellate reviews;

   d. Summary suspension or summary restriction;

   e. Hospital and Medical Staff performance improvement activities;

      Utilization reviews;

   f. Other Hospital, Medical Staff, department, service, or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

   g. Matters of inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter that may be considered material to qualifications for affiliation; and inspection and/or verification of educational records, Medical Staff records, licensing

board records, professional liability insurance records, contact with personal and/or professional references and any other records or third parties that may have direct bearing upon the application; and

h. Any other matter that might directly or indirectly have an effect on competence, on patient care or on the orderly operation of this Hospital.

B. Provisions in these Bylaws relating to immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

XII. FAIR HEARING PROCEDURES

A. Only the following decisions or recommendations relating to Medical Staff members, if based on professional competence or professional conduct and if deemed adverse pursuant to Article XII, Section C, shall entitle a practitioner as a matter of right to a hearing under this Plan:

1. Denial of staff appointment or reappointment (except that a determination that an application for appointment cannot be processed because the individual does not meet basic eligibility requirements does not trigger hearing rights).

2. Denial of requested advancement in Medical Staff category when such denial is based on professional competence or conduct.

3. Reduction of Medical Staff category when such reduction is based on professional competence or conduct.

4. Suspension or restrictions of staff membership, except for summary suspensions or restrictions lasting fourteen (14) or fewer days.

5. Revocation of staff appointment.

6. Reduction of clinical privileges.

7. Denial of requested clinical privileges.

8. Suspension or restriction of clinical privileges, except for summary suspensions or restrictions lasting fourteen (14) or fewer days.

9. Revocation of clinical privileges.

10. Imposition of mandatory consultation or mandatory proctoring requirements, but only if the consultant or proctor must approve the course of treatment in advance.

B. No other actions or recommendations will entitle the Practitioner to a hearing under the Fair Hearing Plan. AHPs are not entitled to procedural rights under this Section of the Bylaws and are instead subject to the process specified in Article VI, Section D.

C. Adverse Recommendations Or Actions. A recommendation or action listed in Article XII, Section A above shall be deemed adverse only when it has been:

1. Recommended or taken by the MEC; or

2. Taken by the Board of Directors under circumstances where no prior right to a hearing existed.

D. Written Notice

In all cases in which the Board of Directors or the MEC shall have made a recommendation or taken an action entitling a practitioner to a hearing, the Chief Executive Officer of the Hospital shall notify the practitioner by certified mail within five (5) days.

1. Written notice shall also inform the practitioner of the following:

a. The proposed action, the reasons therefore, and the practitioner's right to a hearing, a request for which must be made within thirty (30) days;

b. Failure to request a hearing and appellate review within the time frame allowed shall be deemed waiver of the right to hearing; failure to appear at a scheduled hearing, without good cause as determined by the Hearing Committee, shall be deemed waiver of the right to hearing. Such waiver shall constitute the practitioner's acceptance of the adverse recommendation or action;

c. The practitioner's right to be accompanied by legal counsel, under the provisions of written notice;

d. The practitioner's right to have a record made of the proceedings, copies of which may be obtained upon payment of the reasonable charges associated with the preparation thereof;

e. The practitioner's right to call, examine and cross-examine witnesses;

f. The practitioner's right to present evidence determined to be relevant by the hearing officer; regardless of its admissibility in

a court of law; and

g. The practitioner's right to submit a written statement at the close of the hearing.

2. In all cases the MEC or Board of Directors may be accompanied by legal counsel.

3. If at the time the hearing is requested, the practitioner intends to be accompanied by legal counsel, the practitioner shall notify the Chief Executive Officer of the Hospital. However, at that time the practitioner may instead specify an intent to be accompanied by legal counsel only if the Hospital is accompanied by its legal counsel. In this case, the Chief Executive Officer of the Hospital shall inform the practitioner of the Hospital's intent by certified mail to the practitioner's home address and within the next five (5) days. Such agreements are binding on each party but may be set aside by mutual consent.

E. Request for Hearing

1. The practitioner shall have thirty (30) days from the date of receipt of the written notice of adverse recommendation or action, to submit to the Chief Executive Officer of the Hospital a request for hearing. The request for hearing must be in writing and delivered by certified mail. Failure to request a hearing within the time allowed, shall be deemed waiver of the right to hearing.

2. Upon receipt of a timely request for hearing, the Chief Executive Officer of the Hospital shall within five (5) days notify the Medical Staff President. The Medical Staff President shall, within ten (10) days after his or her receipt of the request for hearing, schedule and arrange for such a hearing and shall notify the practitioner by certified mail of the following:

a. The date, place, and time of the hearing, which date shall not be less than thirty (30) days after the date of the original written notice of adverse action, unless an earlier date is established by mutual agreement.

b. A list of the witnesses expected to testify at the hearing by request of the Hospital or Medical Staff.

c. When a request for hearing is received from a practitioner who is then under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made but no more than ten (10) days from the date of

receipt of the request for hearing.

d. When a hearing is requested, the Medical Staff President shall appoint a Hearing Committee which shall be composed of five (5) members of the Active Medical Staff. No appointed member shall have previously participated in the process that led to the adverse recommendation except at a vote of the Medical Staff as a whole. When feasible, at least one (1) member of the committee shall be of the same specialty as the practitioner. The Hearing Committee shall elect its chairperson.

e. The Board of Directors when its action has prompted the hearing, shall appoint one (1) of its members to represent it at the hearing, to present the facts in support of its decision or action, and to examine witnesses. These representatives shall not participate in the deliberations of the Hearing Committee.

F. Hearing Procedure.

1. The attendance of the practitioner for whom the hearing has been scheduled is required. Failure to appear, without good cause, as determined by the Hearing Committee, shall be deemed waiver of the right to hearing.

2. The chairman of the Hearing Committee shall preside over the hearing, determine the order of procedure, and maintain decorum. All participants in the hearing shall have a reasonable opportunity to present relevant oral and written evidence.

3. The hearing need not be conducted strictly according to the rules of law related to the examination of witnesses or the presentation of evidence. Any relevant matter upon which reasonable persons customarily rely in the conduct of serious affairs shall be considered.

4. All written material presented shall become part of the hearing record. The Hearing Committee shall keep an accurate record of its proceedings by means of a recording device.

5. Throughout the hearing process both parties shall have the following rights: To call, examine, and cross-examine witnesses on any matter relevant to the hearing; to introduce documentary evidence; to challenge witnesses; and to rebut evidence. The practitioner shall also have the right to be accompanied by legal counsel according to the provisions of Article XII, Section D. The practitioner shall be responsible for supporting his/her challenge to the adverse

recommendation or action by an appropriate showing that the charges or grounds lack any factual basis, or that actions based thereon are arbitrary, unreasonable, or capricious. If the practitioner does not testify on his/her own behalf, he/she may be called and examined.

6. The Hearing Committee shall be entitled to consider any pertinent material contained on file in the Hospital, and all other information relevant to appointment to the Medical Staff or delineation of clinical privileges.

7. The chair of the Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of participants or for the purpose of obtaining new or additional evidence or consultation. In no case will the recess be longer than five (5) days.

8. Upon conclusion of presentation of evidence and examination and cross-examination of witnesses, the hearing shall be closed.

9. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner.

10. Within ten (10) days of the final adjournment of the hearing, the Hearing Committee shall submit a written report and recommendation to either the Medical Staff or the Board of Directors dependent on whose initial adverse recommendation or action prompted the hearing. The report will state the basis of the Hearing Committee's recommendation and shall include a recommendation for confirmation, modification, or rejection of the original adverse recommendation or action of the Medical Staff or Board of Directors. A copy shall at the same time be delivered to the practitioner involved by certified mail to the affected practitioner's home address and to the President of the Medical Staff.

11. Within ten (10) days of receiving the Hearing Committee's report and recommendation, the MEC or the Board of Directors, as appropriate, shall meet to consider the report and make a decision to confirm, modify or reject the original adverse recommendation or action. This decision will be communicated to the practitioner by the Chief Executive Officer of the Hospital within thirty (30) days by certified mail.

12. The MEC will forward its decision and recommendation to the Board of Directors. The Board will consider the recommendation at their next regular meeting. The Board's decision, whether favorable or adverse, will be subject to appellate review, only when the initial adverse action

was taken by the MEC.

13. When the initial adverse action was taken by the Board of Directors, its decision following hearing will be considered final.

G. Request for Appellate Review

1. Within five (5) days after receiving the decision of the MEC or Board of Directors, the affected practitioner may request an appellate review by the Board of Directors. The request must be in writing and delivered by certified mail to the Board of Directors in care of the Chief Executive Officer of the Hospital. Failure to request an appellate review within the time allowed shall be deemed waiver of the right to appellate review.

2. At the same time, the practitioner may submit a written statement in which those factual and procedural matters of disagreement and reason for such disagreement shall be specified. This written statement may cover matters raised at any step in the procedure related to the appeal. Legal counsel may assist in its preparation. This written statement must accompany the request for appellate review. A copy shall be sent to the MEC.

3. Within five (5) days after receiving the practitioner's statement, the MEC or the Board of Directors may submit a similar statement to the Chief Executive Officer of the Hospital. The Chief Executive Officer of the Hospital will forward this statement to the practitioner and to the chairman of the Board of Directors.

4. The statement will be considered at the appellate review.

5. Within ten (10) days after receipt of a request for appellate review, the chairman of the Board of Directors shall schedule and arrange for an appellate review hearing. The chairman of the Board shall notify the practitioner by certified mail of the time, place and date of the appellate review. The date thereof shall be as soon as it is mutually agreeable, but not more than thirty (30) days from the date of receipt of the request for appellate review. When a request for appellate review is received from a practitioner who is then under suspension, the appellate review hearing shall be held within ten (10) days from the date of receipt of the request.

H. Appellate Review Procedure

1. The attendance of the practitioner for whom the appellate review is scheduled is required. Failure to appear, without good cause at the

discretion of the Board of Directors, shall be deemed forfeiture of the right to appellate review.

2. The proceedings by the Board of Directors shall be in the nature of an appellate review, based upon the record of the Hearing Committee proceedings and the written statements of both parties without taking additional evidence. However, the Board may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination and confrontation applicable to the proceedings before the Hearing Committee. The practitioner shall have the right to be represented by legal counsel.

3. The appellate review body shall keep an accurate record of the proceedings by means of a recording device.

4. Upon conclusion of the presentation of evidence, the appellate review shall be closed. The Board will conduct its deliberations outside the presence of the practitioner and the practitioner's attorney. Following the appellate review, the Board may refer the matter to the Medical Staff for further review and recommendation. This action shall not extend the time within which the Board shall render its final decision.

5. Within thirty (30) days of the adjournment date, the Board of Directors shall render a final decision in writing and shall deliver copies thereof to the practitioner and to the MEC personally or by certified mail. The final decision shall include a statement outlining the basis for the Board's decision.

6. The final decision of the Board of Directors following the appellate review set forth in this Article shall be effective immediately and shall not be subject to further appeal.

I. Limitation on Hearing Procedure

No practitioner shall be entitled as a matter of right to more than one hearing before the Board of Directors on any single matter which may be the subject of an appeal under Article XII, Sections A and C, without regard to whether such subject is the result of action by the MEC or the Board of Directors.

J. Records

All records and tapes of the proceedings provided for in this Article shall be kept on file in the office of the Chief Executive Officer of the Hospital until all applicable statutes of limitation expire, or, if a judicial appeal is then pending, until the final determination of such appeal.

XIII. HISTORY AND PHYSICAL EXAMINATION

A. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a qualified licensed individual in accordance with state law and Hospital policy.

B. If the medical history and physical examination was documented prior to admission or registration, an updated history and physical examination of the patient must be documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be documented by a qualified licensed individual in accordance with state law and Hospital policy.

C. The content of a complete and focused history and physical examination is delineated in Hospital policy.

RULES AND REGULATIONS

I. ORIENTATION

The Hospital will provide an orientation for Medical Staff members designed to welcome and inform them of the Medical Staff framework for governance, pertinent aspects of patient care, organizational policies and procedures and necessary safety measures.

II. ADMISSION AND DISCHARGE OF PATIENTS

A. The Hospital shall accept patients for care and treatment.

B. However, in those cases of patients suffering illness or injuries whose care requires specialized services or equipment not available at the Hospital, they shall be admitted only until they can be transferred to an appropriate facility.

C. A patient may be admitted to the Hospital only by a member of the Medical Staff with admitting privileges.

D. A member of the Medical Staff shall be responsible for medical care and treatment of each patient in the Hospital, for the prompt completion and accuracy of the medical record, for necessary special instructions, for transmitting reports of the conditions of the patients to the referring practitioner and to the patient or surrogate. Adequate notice shall be given whenever these responsibilities are transferred to another staff member.

E. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

F. When a patient to be admitted on an emergency basis does not have a private physician and has no preference, the patient will be assigned to the MD/DO on Hospital call. The Medical Staff shall provide a rotation schedule of physicians on Hospital call.

G. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever their patients might be a source of danger from any cause whatever.

H. Patients admitted to the Hospital for dental or podiatric care shall receive the same basic medical appraisal as patients for other services. This includes an admission history and physical examination and an evaluation of the overall

risk. The responsible dentist or podiatrist shall take into account the recommendation of this consultation in the overall assessment of the specific procedure proposed and the effect of the procedure on the patient. When significant medical abnormality is present, the final decision must be a joint responsibility of the dentist or a podiatrist and the medical consultant.

I. Patients shall be discharged from inpatient status only pursuant to an order by an MD/DO, dentist, podiatrist, APP or AHP credentialed to do so. Should a patient leave the Hospital against the advice of the attending practitioner or without proper discharge, the patient will be requested to sign a release form and a notation shall be made on the patient's medical record.

J. In the event of a patient death, the deceased shall be pronounced dead by an MD/DO. In the event of a hospice death, the Hospital will follow State guidelines.

K. Autopsies are to be performed when appropriate. Deaths in which autopsies are to be considered will include those in which state statutes define the case as a coroner's case and/or when the cause of death is uncertain. An autopsy may be performed only with a written consent signed in accordance with State law. The attending practitioner shall be informed if an autopsy is performed. The autopsy will be completed by the current the Hospital contracted autopsy service. The autopsy report may be used as a source of clinical information in mortality review/quality assessment and improvement activities.

III. MEDICAL RECORDS

A. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be defined by Hospital policy.

B. A history and physical examination may be performed by a MD/DO, dentist, podiatrist, APP or allied health professional with privileges to do so with review and signature requirements as stated in Hospital policy.

C. A non-credentialed licensed practitioner may complete a history and physical examination for a patient admitted to the Hospital provided a credentialed practitioner of the Hospital performs a review of the history and physical documents; conducts a second assessment to confirm the information and findings; updates any information and findings as necessary (including a summary of the patient’s condition and course of care during the interim period) and the current physical/psychosocial status; and signs and dates the information as an attestation to it being current.

D. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.

E. All clinical entries in the patient's medical record must be accurately timed, dated and authenticated.

F. Pertinent progress notes shall be recorded at the time of observations, sufficient to permit continuity of care and to allow another practitioner to assume care of the patient at any time. Recording of the note should not exceed twenty-four (24) hours after the observation of the patient. Each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments. Progress notes shall be recorded at least daily except for swing bed and respite patients.

G. An operative progress note is to be documented in the medical record immediately after surgery to provide pertinent information for any individual required to attend to the patient.

H. A brief operative note is documented by the surgeon on the chart immediately following the procedure. This note includes at least: the name of the procedure, the name(s) of the primary surgeon and assistants, findings, complications (if any), estimated blood loss and condition on discharge from surgery.

I. Complete operative reports are the responsibility of the operating surgeon and are to be recorded in the medical record immediately following the surgical procedure. They shall include: the patient's name and medical record number; the date and times of the surgery; the pre- and postoperative diagnoses; the procedure(s) performed; the names of the surgeons, assistants, and other practitioners who performed surgical tasks; type of anesthesia; a narrative of the technical procedure performed, findings, and specimens removed or altered; type of prosthetic devices, grafts, tissues, transplants, or other devices implanted, if any; estimated blood loss; and complications, if applicable. Operative reports shall be promptly dated and authenticated by the surgeon.

J. Operative reports not completed within twenty-four (24) hours will be considered delinquent.

K. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the

consultant note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

L. All relevant diagnoses established by the time of discharge, as well as all operative procedures performed, are recorded.

M. A discharge summary shall be recorded on all medical records except in the case of normal newborn infants. In such cases, a formal progress note must be recorded to include instructions given to the family. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.

N. The medical record is the property of the Hospital and is maintained for the benefit of the patient, the Medical Staff, and the Hospital. It is the responsibility of the Hospital to safeguard the information in the record against loss, defacement, tampering, or use by unauthorized persons. Written consent of the patient or the patient's legally qualified representative is required for release of medical information to persons not authorized to receive the information. Records may be removed from the Hospital's jurisdiction only in response to a court order, statute or subpoena.

O. Free access to all medical records of all patients will be offered to members of the Medical Staff for study, research, and performance improvement activities consistent with preserving the confidentiality of personal information.

P. The patient’s discharge summary shall be completed (documented and authenticated) upon discharge or as soon as possible thereafter to provide timely access to view online, download and transmit his/her health information. In case the practitioner fails to record the discharge summary in a timely fashion (no later than five (5) days following discharge), the practitioner will be notified by Health Information Services of the delinquency. If the summary is not complete and signed within seven (7) days of the patient’s discharge, Health Information Services will notify the Chief Executive Officer of the Hospital, the Medical Staff President and the practitioner that Hospital admission privileges will be suspended. If the practitioner feels mitigating circumstances prevail, the President of the Medical Staff may be appealed to in writing, with a copy to the Chief Executive Officer, by the practitioner. If the President of the Medical Staff concurs with the practitioner, privileges may be continued. Admission privileges will be reinstated by authority of the President of the Medical Staff after notification to the President of the Medical Staff and the Chief Executive Officer by Health Information Services that delinquencies had been resolved. In the event the recording delinquencies involve the

Medical Staff President, the Vice-President or in his/her absence, the Secretary shall act in the authorization role as the President. Health Information Services will report suspension in the report at the MEC meeting. MEC will consider further corrective action for patterns of suspension or other delinquencies.

Q. Swing Bed patients' medical records shall meet the documentation required by the State of Wisconsin for skilled care. The attending MD/DO or designee must evaluate Swing Bed patients admitted from outside the facility within twenty-four (24) hours after their admission to Swing Bed and document that visit.

R. Practitioners will refrain from using unapproved abbreviations as determined by Hospital policy.

S. The patient's medical record shall be recorded within the timeframes outlined in the Hospital Medical Staff Bylaws, Rules and Regulations and the Hospital policies. Failure to comply with these timeframe requirements may result in admitting privilege suspension which is further outlined in Article III, Section P.

IV. CONSULTATIONS

A. The patient's practitioner shall be responsible for requesting consultations when indicated. Consultations may be considered where the diagnosis is obscure after ordinary diagnostic procedures have been completed, in unusually complicated situations where specific skills or other practitioners may be needed, or when requested by the patient or family.

B. The patient's attending practitioner is responsible for the coordination of the care, treatment, and services among the practitioners involved in a patient's care, treatment, and services.

C. It shall be the duty of the Medical Staff, through the Medical Staff President to make sure that members of the Medical Staff do not fail in the matter of calling consultants as needed.

V. GENERAL RESPONSIBILITIES

A. A general consent form, signed by or on behalf of every patient, must be obtained prior to care at the time of admission. The practitioner should be notified whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.

B. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment or surgical procedure should be obtained and documented in the medical record.

C. All orders shall be recorded clearly by the ordering Medical Staff member responsible for ordering, providing or evaluating the service. A verbal or telephone order shall be authenticated by a properly credentialed Medical Staff member in the electronic medical record within forty-eight (48) hours. A covering appropriately credentialed provider may authenticate the verbal order of an ordering provider when the ordering provider is off duty or otherwise unable to authenticate. Verbal and telephone orders shall be strictly confined to circumstances in which patient care needs require them.

D. Any licensed health care professional may take verbal orders except for medication orders or medical treatments that are outside their scope of practice, which must be given to a registered nurse or licensed pharmacist.

E. Only a licensed practitioner may order restraints. Hospital policy will define the maximum time for restraint usage, intervals for renewing restraint orders, criteria for periodic assessment and observation of the patient.

F. The MEC or its appointee shall be responsible for the maintenance of a medical library sufficient for the needs of the Hospital.

G. The MEC, with input from members of the Active Medical Staff, is to annually review order sets, protocols and guidelines.

H. Each member of the Medical Staff shall be required to comply with the policies and Rules and Regulations of the Hospital and Medical Staff.

I. Each member of the Medical Staff shall be required to utilize hospital-endorsed electronic documentation systems.

J. When on call, each member of the Medical Staff shall be able to present to the Hospital within thirty (30) minutes or shall name a member of the Medical Staff who shall be able to present to the Hospital within thirty (30) minutes. In case of failure to name such a member, the Chief Executive Officer of the Hospital or the President of the Medical Staff shall have authority to call any member of the Active Medical Staff in such an event. In the event of an emergency situation and a member is unable to respond, contingency plans shall be implemented.

K. Any time a transfer of patient care occurs between providers, pertinent information must be relayed with opportunity for interactive communication.

VI. GENERAL RULES REGARDING SURGICAL CARE

A. Except in emergencies, the preoperative diagnosis and requested test results must be available prior to any surgical procedure. If not available, the operation shall be cancelled. In an emergency the practitioner shall make a comprehensive note regarding the patient's condition prior to induction of anesthesia.

B. A patient admitted for dental or podiatric care is a dual responsibility involving the dentist or podiatrist and MD/DO member of the Medical Staff.

1. Dentist's responsibilities:

a. A detailed dental history justifying Hospital admission.

b. A detailed description of the examination of the oral cavity and a preoperative diagnosis.

c. A complete operative report, describing the findings and technique. Tissue shall be submitted according to the approved list of specimens not requiring pathological examination.

d. Progress notes as are pertinent to the oral condition.

e. Clinical summary.

2. Podiatrist's responsibilities:

a. A detailed podiatric history justifying Hospital admission.

b. A detailed description of the physical examination that relates to podiatry and a preoperative diagnosis.

c. A complete operative report, describing the findings and technique. Tissue shall be submitted according to the approved list of specimens not requiring pathological examination.

d. Progress notes as are pertinent to the condition of treatment.

e. Clinical summary.

3. MD/DO responsibilities:

   a. Ensure that a history and physical examination is performed and recorded and updated as required by the hospital Bylaws, Rules and Regulations, and as required by law.

   b. Be available to the Hospital within ten (10) minutes during the administration of anesthesia and for one (1) hour postoperatively and immediately available by telephone.

4. The discharge of the patient shall be recorded by the dentist, podiatrist, MD/DO, or APP member of the Medical Staff.

C. Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.

D. A pregnancy test will be done prior to any intrauterine instrumentation or any surgical procedure on the body of the uterus in all women in the childbearing years. Exceptions will be cases of incomplete abortion and cases of cesarean section.

E. Postoperatively, all preoperative orders will be reviewed and modified as needed to reflect the patient’s postoperative status.

F. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post anesthetic follow-up of the patient's condition.

G. In any surgical procedure with significant surgical risk, there must be an appropriate assistant present and scrubbed.

H. Specified tissues removed at the operation shall be sent to the pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. The authenticated report shall be made a part of the patient's record.

I. The CRNA, who is licensed as an advanced practice nurse prescriber, shall work in a documented collaborative relationship with the Medical Staff. The CRNA may complete the post-anesthesia follow-up report, and

the report must include cardiopulmonary status, level of consciousness, any follow-up care and/or observations, and any complications occurring during post-anesthesia recovery.

VII. GENERAL RULES REGARDING OBSTETRICAL CARE

A. The responsible practitioner must be available to the Hospital as defined by policy, during administration of oxytocics and must be immediately available by telephone.

B. Estimated blood loss for each delivery shall be noted on the patient's medical record.

C. The current obstetrical record shall include a complete prenatal record. The prenatal record shall be a legible copy of the practitioner's office record transferred to the Hospital before admission, but a comprehensive OB admission note must be recorded upon admission that includes pertinent additions to the history and physical examination at the time of admission. In the event a prenatal record is not available, a comprehensive history and physical examination shall be entered into the medical record.

VIII. EMERGENCY SERVICES

A. The Medical Staff shall provide emergency and urgent care services in accordance with EMTALA and all other applicable laws and standards by practitioners who are privileged appropriately to provide urgent or emergent care.

B. In accordance with the Hospital's policies, any patient coming to the emergency department (or urgent care) shall be provided with an appropriate medical screening examination by a qualified medical person (which shall include any of the following with appropriate training: Any member of the Medical Staff, any Allied Health Professional or any registered nurse). If the patient is determined to have an emergency medical condition, appropriate stabilizing treatment and subsequent care will be provided in accordance with the Hospital's EMTALA policy.

C. An appropriate medical record shall be kept for every patient receiving emergency or urgent care services, and this shall be incorporated in the patient's Hospital record. The record shall include:

1. Adequate patient identification;

2. Information concerning time of the patient's arrival and how transported;

3. Pertinent history of the injury or illness including details relative to first aid or emergency care given prior to arrival at the Hospital;

4. Description of significant clinical, laboratory, and roentgenological findings;

5. Diagnosis;

6. Diagnostic and therapeutic orders;

7. Appropriate informed consent;

8. Condition of the patient on discharge or transfer; and

9. Final disposition, including instructions given to the patient and/or his family, relative to necessary follow up care.

D. Each patient's medical record shall have appropriate counter-signature where indicated by applicable law, accreditation standards, or Hospital policy.

E. The medical staff will be called upon to participate in the care of mass casualties at the time of any major disaster.