

BYLAWS

OF THE

MEDICAL STAFF

OF

HALIFAX HEALTH MEDICAL CENTER

Adopted by the Medical Staff on March 21, 2017

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Table of Contents

PREAMBLE 8

DEFINITIONS 9

ARTICLE I- NAME..... 13

ARTICLE II- PURPOSES 14

ARTICLE III- CATEGORIES OF THE MEDICAL STAFF 15

 3.1 THE HONORARY MEDICAL STAFF..... 15

 3.2 THE ACTIVE MEDICAL STAFF..... 15

 3.2-1 Requirements for Active Staff Membership..... 15

 3.2-2 Obligations for Active Staff Membership 15

 3.3 THE ASSOCIATE STAFF..... 16

 3.3-1 Requirements for Associate Staff Membership and Consideration for Advancement to Active Staff 16

 3.3-2 Obligations for Associate Staff Membership 17

 3.4 SENIOR ACTIVE MEDICAL STAFF..... 17

 3.4-1 Requirements for Senior Active Medical Staff Membership..... 17

 3.4-2 Obligations for Senior Active Medical Staff Membership..... 18

 3.5 RESIDENT AFFILIATE 18

 3.6 COURTESY AFFILIATE STAFF 18

 3.7 COMMUNITY AFFILIATE 19

 3.8 COURTESY STAFF..... 19

 3.8-1 Requirements for Courtesy Staff Membership..... 19

 3.8-2 Obligations of Courtesy Staff Membership..... 19

 3.9 OUTPATIENT FACILITY STAFF 20

 3.10 NON PHYSICIAN PROVIDERS..... 20

 3.10-1 Clinical Duties and Prerogatives 21

 3.10-2 Responsibilities..... 21

 3.10-3 Functions and Limitations of NPP 21

 3.10-4 Protection from Liability 21

ARTICLE IV- MEMBERSHIP IN THE MEDICAL STAFF 23

 4.1 NATURE OF MEDICAL STAFF MEMBERSHIP 23

 4.2 QUALIFICATIONS FOR MEMBERSHIP 23

 4.2-1 General Qualifications 23

 4.2-2 Specific Qualifications 23

 4.3 CONDITIONS AND DURATION OF APPOINTMENT..... 24

 4.3-1 Resignation from the Medical Staff 26

4.3-2 Leave of Absence	26
4.3-3 Automatic Relinquishment	27
4.4 NON-DISCRIMINATION POLICY	27
4.5 HOSPITAL NEED AND ABILITY TO ACCOMMODATE	27
4.5-1 Availability of Facilities/Support Services	28
4.5-2 Medical Staff Development Plan	28
4.5-3 Effects of Declination	28
4.6 PEER REVIEW.....	28
4.6-1 Peer Review for Patient Safety	28
4.6-2 Professional Conduct and Disciplinary Peer Review	29
ARTICLE V- PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT	31
5.1 APPOINTMENT AND REAPPOINTMENT.....	31
5.1-1 Application for Clinical Privileges and Medical Staff Membership	31
5.1-2 Required Information	31
5.1-3 Basic Responsibilities, Releases and Consents	33
5.1-4 Medical Staff Leadership Review and Invitation to Apply	34
5.1-5 Miscellaneous Provisions.....	35
5.2 APPOINTMENT PROCESS	35
5.2-1 Appointment Recommendations	35
5.2-2 Decision by Governing Body	36
5.3 REAPPOINTMENT PROCESS.....	36
5.3-1 Application for Reappointment.....	36
5.3-2 Recommendation by Credentials Committee	36
5.3-3 Reapplication Upon Denial.....	37
5.4 EXPEDITED PROCESS.....	37
ARTICLE VI - CLINICAL PRIVILEGES.....	38
6.1 GENERAL PROVISIONS	38
6.1-1 Admitting Privileges	39
6.1-2 Medical History and Physical Examination Requirements	39
6.2 ADDITIONS TO CLINICAL PRIVILEGES	39
6.3 BASIS FOR PRIVILEGE DETERMINATION	40
6.4 DELINEATION	41
6.5 TELEMEDICINE PRIVILEGES	41
6.6 USE OF ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS, PODIATRISTS AND DENTISTS/ORAL SURGEONS.....	42

6.7 LIMITED LICENSURE PRACTITIONERS	43
6.8 UNAVAILABLE CLINICAL PRIVILEGES	44
6.9 TEMPORARY PRIVILEGES	44
6.9-1 Circumstances	44
6.9-2 Locum Tenens Practitioners	45
6.9-3 Special Conditions of Supervision	45
6.9-4 Termination of Temporary Privileges	45
6.10 DISASTER PRIVILEGES	46
6.11 PROTECTION FROM LIABILITY	47
ARTICLE VII- CORRECTIVE ACTION	48
7.1 PROCEDURE FOR CORRECTIVE ACTION	48
7.1-1 Initiation of Corrective Action	48
7.1-2 Form of Request for Corrective Action	48
7.1-3 Records; Pre-Credentials Committee Meetings	48
7.1-4 Credentials Committee Powers	48
7.1-5 Credentials Committee Procedures	49
7.1-6 Notice to the Chief Executive Officer	49
7.1-7 Notice of Adverse Recommendation or Action	49
7.2 SUMMARY SUSPENSION	49
7.2-1 Initiation	49
7.2-2 Credentials Committee Procedure	49
7.2-3 Hearing	50
7.2-4 Alternate Medical Coverage	50
7.3 AUTOMATIC SUSPENSION	50
7.3-1 Action of the State Board of Medical Examiners	50
7.3-2 Duty of the Chief of Staff	51
7.4 PROTECTION FROM LIABILITY	51
ARTICLE VIII - HEARINGS AND APPEALS	52
8.1 RIGHT TO HEARING AND APPELLATE REVIEW	52
8.1-1 General Provisions	52
8.1-2 Grounds for Hearing	52
8.1-3 Actions Without Hearing	52
8.2 NOTICE OF ACTION; REQUEST FOR HEARING	52
8.2-1 Notice of Action Warranting Hearing	52
8.2-2 Request for Hearing	53

- 8.2-3 Waiver by Failure to Request a Hearing.....53
- 8.3 NOTICE OF HEARING AND CHARGES; FAILURE TO ATTEND; RESCHEDULING HEARING..... 54**
 - 8.3-1 Notification of Hearing 54
 - 8.3-2 Notice of Charges 54
 - 8.3-3 Failure to Appear 54
 - 8.3-4 Rescheduling of Hearings 54
- 8.4 HEARING PROCEDURE 55**
 - 8.4-1 Hearing Panel..... 55
 - 8.4-2 The Presiding Officer 55
 - 8.4-3 Witness Lists..... 55
 - 8.4-4 Procedural Disputes..... 56
 - 8.4-5 Hearing Costs..... 56
 - 8.4-6 Rights of the Parties 56
 - 8.4-7 Admissibility of Evidence 56
 - 8.4-8 Record of Hearing 57
 - 8.4-9 Burden of Proof 57
 - 8.4-10 Adjournment and Conclusion..... 57
 - 8.4-11 Deliberation, Recommendation and Report 57
- 8.5 APPEAL TO THE GOVERNING BODY 58**
 - 8.5-1 Time for Appeal 58
 - 8.5-2 Grounds for Appeal..... 58
 - 8.5-3 Time, Date Notice 58
 - 8.5-4 Appellate Body 58
 - 8.5-5 Appeal Procedure 58
 - 8.5-6 Submission of Written Statements 59
 - 8.5-7 Miscellaneous 59
- 8.6 HEARING FOR NEW APPLICANT (Hearings authorized by Section 8.1-2(i)) 60**
 - 8.6-1 Pre-Hearing Procedure 60
 - 8.6-3 Hearing Procedure 60
 - 8.6-4 Conclusion of Hearing 60
 - 8.6-5 General Provisions 61
- 8.7 FINAL APPELLATE REVIEW DECISION BY GOVERNING BODY 61**
 - 8.7-1 Decision..... 61
 - 8.7-2 Right to One Hearing 61

8.8 PROTECTION FROM LIABILITY.....	61
ARTICLE IX - OFFICERS.....	62
9.1 OFFICERS OF THE MEDICAL STAFF	62
9.2 QUALIFICATIONS OF OFFICERS	62
9.3 ELECTION OF OFFICERS.....	62
9.4 TERM OF OFFICE.....	62
9.5 VACANCIES IN OFFICE.....	63
9.5-1 Vacancy.....	63
9.5-2 Removal	63
9.6 DUTIES OF OFFICERS.....	63
9.6-1 Chief of Staff	63
9.6-2 Chief-Elect	64
9.6-3 Secretary/Treasurer	64
ARTICLE X- CLINICAL DEPARTMENTS	65
10.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND SERVICES.....	65
10.1-1 Clinical Departments.....	65
10.1-2 Hospital Professional Services	65
10.2 QUALIFICATIONS, SELECTION AND TENURE OF DEPARTMENT CHAIRS.....	65
10.2-1 Election/Qualification	65
10.2-2 Removal	66
10.2-3 Vacancy.....	66
10.3 RESPONSIBILITIES OF DEPARTMENT CHAIRS	66
ARTICLE XI -COMMITTEES.....	68
11.1 MEDICAL EXECUTIVE COMMITTEE.....	68
11.1-1 Composition	68
11.1-2 Duties	68
11.1-3 Actions	69
11.1-4 Regular Meetings	69
11.1-5 Special Meetings	69
11.1-6 Removal of Members.....	69
11.1-7 Conflict Management.....	70
11.2 CREDENTIALS COMMITTEE.....	70
11.2-1 Composition	70
11.2-2 Duties	70
11.2-3 Meetings.....	71

11.3 BYLAWS COMMITTEE	71
11.3-1 Composition.....	71
11.3-2 Meetings.....	71
11.3-3 Duties	71
11.4 OTHER STANDING AND SPECIAL COMMITTEES	72
11.5 MEETINGS OF ALL COMMITTEES.....	72
ARTICLE XII- MEDICAL STAFF MEETINGS.....	73
12.1 ANNUAL MEETING	73
12.2 REGULAR MEETINGS.....	73
12.3 SPECIAL MEETINGS	73
12.4 QUORUM.....	73
12.5 STURGIS STANDARD CODE OF PARLIAMENTARY PROCEDURE	74
12.6 ATTENDANCE REQUIREMENTS	74
12.6-1 Medical Staff Meetings.....	74
12.6-2 Department Meetings.....	74
12.7 AGENDA.....	74
ARTICLE XIII- MEDICAL STAFF DUES AND FEES.....	75
13.1 DUES	75
13.2 FEES.....	75
ARTICLE XIV- RULES AND REGULATIONS	76
14.1 GENERAL	76
14.2 ADOPTION AND AMENDMENT.....	76
14.3 URGENT ACTION.....	76
ARTICLE XV- AMENDMENTS AND REVISIONS	77
15.1 REQUEST BY MEDICAL EXECUTIVE COMMITTEE	77
15.2 REQUEST BY MEDICAL STAFF	77
ARTICLE XVI- MEDICAL RECORDS	78
16.1 MEDICAL RECORDS.....	78
16.1-1 Compliance with Hospital and Medical Staff Policies	78
16.1-2 Admission History and Physical Examination.....	78
16.1-3 History and Physical Required Prior to Procedure	78
ARTICLE XVII -ADOPTION	79

PREAMBLE

WHEREAS, Halifax Health Medical Center is a facility of a Special Taxing District organization and is organized under the laws of the State of Florida; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, education and research; and

WHEREAS, it is recognized that the Medical Staff is responsible to the Governing Board of the Special District for the quality and delivery of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer "CEO" and Governing Body are necessary to fulfill the Hospital's obligations to its patients;

NOW THEREFORE, the doctors of medicine, doctors of osteopathy, doctors of dentistry, doctors of psychology, and doctors of podiatry practicing in this Hospital hereby organize themselves into a Medical Staff for these purposes and in conformity with these Bylaws.

DEFINITIONS

1. **ADMITTING PRIVILEGES** means the prerogatives granted to certain Members of the Staff to admit patients to the Hospital.
2. **ADVERSE ACTION** means an action that adversely affects an individual's Medical Staff membership or clinical privileges. An Adverse Action shall include a denial or termination of Medical Staff membership, or a denial, reduction, or termination of clinical privileges.
3. **APPLICANT** means an individual who has completed the pre-application process and has been formally invited to apply for membership for appointment set forth in Article V, or a Member who has completed the process set forth in Article V for reappointment or an increase in or change to the Member's clinical privileges.
4. **BOARD CERTIFICATION** means having completed an approved educational training program and an evaluation process including an examination designed to assess knowledge, skills, and experience necessary to provide quality patient care in that specialty. For physicians, Board Certification shall be granted from an American Board of Medical Specialties (ABMS) member board, or from a member board of the American Osteopathic Association (AOA). For podiatrists, Board Certification shall be granted from the American Board of Podiatric Surgery (ABPS). For dentists and dental surgeons, Board Certification shall be granted from the American Board of Oral/Maxillofacial Surgeons (ABOMS). For Physician Assistants, Board Certification shall be granted from the National Commission on Certification of Physician Assistants (NCCPA). For Advanced Registered Nurse Practitioners, Board Certification shall be granted from either the American Nurses Credentialing Center (ANCC) or the American Academy of Nurse Practitioners (AANP). For Certified Nurse Midwives, Board Certification shall be granted from American Midwifery Certification Board (AMCB). For Certified Registered Nurse Anesthetists, Board Certification shall be granted from National Board of Certification & Recertification of Nurse Anesthetists (NBCRNA). When applicable, all Practitioners shall become Board Certified in their specialty within five (5) years of eligibility and maintain their status as Board Certified thereafter; provided, however, that Members who have been members for at least twenty (20) years as of the date these Bylaws are approved by the Board of Commissioners shall not be required to obtain and maintain Board Certified status.
5. **BOARD RECERTIFICATION** for physicians. Board Recertification shall be granted from an American Board of Medical Specialties (ABMS) member board, or from a member board of the American Osteopathic Association (AOA) or the National Board of Physicians and Surgeons (NBPAS). For podiatrists, Board Certification shall be granted from the American Board of Podiatric Surgery (ABPS). For dentists and dental surgeons, Board Certification shall be granted from the American Board of Oral/Maxillofacial Surgeons (ABOMS). For Physician Assistants, Board Certification shall be granted from the National Commission on Certification of Physician Assistants (NCCPA). For Advanced Registered Nurse Practitioners, Board Certification shall be granted from either the American Nurses Credentialing Center (ANCC) or the American Academy of Nurse Practitioners (AANP). For Certified Nurse Midwives, Board Certification shall be granted from American Midwifery Certification Board (AMCB). For Certified Registered Nurse Anesthetists,

Board Certification shall be granted from National Board of Certification & Recertification of Nurse Anesthetists (NCBRNA). When applicable, all Practitioners shall become Board Certified in their specialty within five (5) years of eligibility and maintain their status as Board Certified thereafter; provided however, that Members who have been Members for at least twenty (20) years as of the date these Bylaws are approved by the Board of Commissioners shall not be required to obtain and maintain Board Certified status.

6. **BOARD ELIGIBLE (PENDING BOARD CERTIFICATION)** means having the education, training, and recommendations sufficient to entitle a Practitioner to sit for the certification examination administered by the appropriate Board Certifying entity.
7. **CERTIFIED MAIL** means registered or certified, return receipt requested.
8. **DEPENDENT HEALTHCARE PROFESSIONAL** means an individual who is permitted both by law and by the Hospital to provide patient care services under the direction or supervision of an independent practitioner, within the scope of the individual's license, and in accordance with individually granted clinical privileges if the dependent practitioner is an NPP.
9. **DISRUPTIVE PROFESSIONAL CONDUCT** means the conduct described as disruptive in the "Professional Conduct of Practitioners" policy adopted by the Medical Staff.
10. **DISTRICT** means the Halifax Hospital Medical Center special taxing district.
11. **ESTABLISHED SUBSECTION** or "Subsection" means a group of Practitioners with similar privileges that has been officially approved by the Executive Committee as constituting a valid subsection within a Department.
12. **EXECUTIVE COMMITTEE** means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Body.
13. **FOCUSED PROFESSIONAL PRACTICE EVALUATION** or FPPE means process whereby the Hospital evaluates the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege at the Hospital.
14. **GOOD STANDING** means a staff member who, during the current term of appointment, has continually maintained or met all qualifications for Medical Staff membership and assigned staff category, has met participation requirements, is not in arrears in the completion of medical records, and has not received a suspension or restriction of membership or privileges.
15. **GOVERNING BODY** means the Board of Commissioners of the Halifax Hospital Medical Center.
16. **HOSPITAL** means Halifax Health Medical Center of Daytona Beach, which includes the main campus in Daytona Beach and the campus in Port Orange and any future locations

operating under the main hospital license. Hospital may also be referred to as “Halifax or Halifax Health” in these Bylaws.

17. **INDEPENDENT HEALTHCARE PROFESSIONAL** means an individual who is permitted by both the applicable Florida State law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual’s license and in accordance with individually granted clinical privileges.
18. **LICENSED INDEPENDENT PRACTITIONER (LIP)** means an individual who is permitted by both the applicable Florida State law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual’s license and in accordance with the individually granted clinical privileges. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Governing Body has determined that the categories of individuals eligible for clinical privileges such as a LIP are physicians (MD or DO), psychologists and neuropsychologists, oral/maxillofacial surgeons (DMD), dentists (DDS or DMD), and podiatrists (DPM).
19. **MEDICAL STAFF** means all physicians (MD or DO), dentists (DMD or DDS), podiatrists (DPM), clinical psychologists, and non-physician providers who are granted privileges to treat patients at the Hospital. The Medical Staff is an integral part of the Hospital and is not a separate legal entity.¹
20. **MEMBER** means a Practitioner who has been granted and maintains Medical Staff membership in good standing pursuant to these Bylaws.
21. **NON PHYSICIAN PROVIDER (NPP)** means an individual, other than a Practitioner, who provides direct patient care services in the Hospital under a defined degree of supervision, and exercising judgment within the areas of documented professional competence consistent with applicable law. NPPs are designated by the Governing Body to be credentialed through the Medical Staff and are granted privileges; however, they are not eligible to be an officer of the Medical Staff.² NPPs include advanced registered nurse practitioners, physician assistants, certified nurse midwives, certified registered nurse anesthetists, and certified registered nurse first assistants.
22. **ONGOING PROFESSIONAL PRACTICE EVALUATION or OPPE** means the ongoing assessment of an existing Member’s performance.
23. **PEER REVIEW** means Peer Review for Patient Safety and Disciplinary Peer Review as described in Section 4.6 of these Bylaws.
24. **PHYSICIAN** means Doctor of Medicine licensed under Chapter 458, Florida Statutes, and Doctor of Osteopathy licensed under Chapter 459, Florida Statutes.
25. **PRACTITIONER** means all physicians, dentists, podiatrists, psychologists and Non Physician Providers who are granted clinical privileges to treat patients at the Hospital, or where appropriate by the context of these Bylaws, is an applicant for membership

¹ 42 CFR §482.12(a)

² 42 CFR §482.12(a)(1)

on the Medical Staff.³

26. PRIVILEGES means authorization granted by the Governing Body to an individual to provide specific patient care services in the Hospital within defined limits, based on the individual's license, education, training, experience, competence, health status, judgment and individual character.⁴ Privileges shall be setting-specific, meaning that the privileges granted shall be based not only on the applicant's qualifications, but also a consideration of the Hospital's capacity and capability to deliver care, treatment, and services within a specified setting.
27. QUALIFIED PHYSICIAN means a Physician who, by virtue of education, training and demonstrated competence, is granted clinical privileges by the Hospital to perform specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine.
28. SERVICE CALL shall refer to the obligation of Members to respond (as required by applicable law and regulation) to requests to come to a Hospital Emergency Department location to provide emergent care or emergent consultation of patients presenting to the Hospital seeking emergent care.
29. TELEMEDICINE involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may be performed via telemedicine link.
30. TELEMEDICINE PRACTITIONER means any licensed and appropriately credentialed member of the Medical Staff who prescribes, renders a diagnosis or otherwise provides clinical treatment to a patient through a telemedicine link.
31. UNASSIGNED PATIENT means any individual who comes to the Hospital for care and treatment who does not have an attending physician; or whose attending physician or designated alternate is unavailable to attend the patient; or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

³ 42 CFR §482.12(a)(1)

⁴ 42 CFR §482.12(a)(6) and FS 395.0191(4)

ARTICLE I- NAME

The name of this organization shall be the Halifax Health Medical Staff.

ARTICLE II-PURPOSES

The purposes of this organization are:

- To work toward the end that all patients admitted to or treated in any of the facilities, departments or services of the Hospital shall receive appropriate care.
- To provide an appropriate educational setting that will maintain scientific and educational standards that will lead to the continued progress of the Members in professional knowledge and skill.
- To initiate and maintain Rules and Regulations for self-government of the Medical Staff.
- To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed and resolved by the Medical Staff with the Governing Body and the Chief Executive Officer.
- To assist the Governing Body by serving as a professional review body to complete professional reviews including quality assurance, performance improvement and Peer Review.⁵
- To serve as the formal organizational structure through which the Medical Staff shall carry out their responsibilities and govern the actions of its Members and other professionals with clinical privileges.
- To provide a mechanism for accountability of the Medical Staff to the Governing Body.⁶
- To maintain compliance of the Medical Staff with regard to applicable Federal, State, and local laws and regulations and applicable accreditation requirements.
- To provide a mechanism for recommending to the Governing Body the appointment and reappointment of Qualified Physicians and making recommendations regarding the clinical privileges for qualified and competent healthcare Practitioners.⁷

None of the foregoing purposes or goals shall be construed to impose a duty or standard of care greater than that otherwise imposed by law. These Bylaws reflect the current organization and functions of the Medical Staff.⁸

⁵ 42 CFR §482.12(a)(5)

⁶ 42 CFR §482.12(a)(5) and 42 CFR §482.22(b)(1)

⁷ MS 01.01.01 EP 6

⁸ 42 CFR §482.22(c)(3) and 42 CFR §482.12(a)(3)

ARTICLE III- CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided into the following categories: Honorary, Active, Associate, Senior Active, Community Affiliate, Resident Affiliate, Courtesy Affiliate, Courtesy, and Outpatient Facility Staff. Non Physician Providers shall have the obligations and duties set forth below. The requirements and obligations of Medical Staff membership in these Bylaws are general in nature and may be limited or restricted by special conditions attached to a Practitioner's appointment or reappointment, by state or federal law or regulations, or other provisions of these Bylaws, the Rules and Regulations, or other policies, commitments, contracts or agreements of the Hospital.⁹

3.1 THE HONORARY MEDICAL STAFF

The Honorary Medical Staff shall consist of Practitioners who are not active in the Hospital or who are honored by emeritus positions. These members shall consist of Practitioners who have retired from active hospital practice and who made significant contributions to the Medical Staff and Hospital during the course of their active practice as determined by the Credentials Committee; or who are of outstanding reputation, but do not necessarily reside in the community. Honorary Staff members shall not be eligible to admit or treat patients, vote, hold office, or serve as voting members on standing Medical Staff Committees. Retirement from practice, without a determination of significant contributions by the Credentials Committee, is not in itself sufficient grounds for appointment to this category.¹⁰

3.2 THE ACTIVE MEDICAL STAFF

3.2-1 Requirements for Active Staff Membership

The Active Medical Staff shall consist of Practitioners who have a minimum of twenty-four (24) patient contacts at the Hospital annually (including inpatient and outpatient admissions and consultations), admit patients, or provide service to patients in the Hospital, who are located close enough to the Hospital to provide care to their patients, and who assume all functions and responsibilities of membership on the Active Medical Staff.

3.2-2 Obligations for Active Staff Membership

Each member of the Active Staff shall discharge the basic obligations of staff Members as required in these Bylaws and any future changes to these Bylaws, the Medical Staff Rules and Regulations, and by directives of the Executive Committee. Active Staff Members should, where appropriate: participate in Service Call for at least one Hospital Emergency Department location (as specified by the Practitioner in their application for appointment or reappointment); provide emergency services, provided continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; actively participate in the quality assessment and performance improvement activities of the Hospital; and provide consultation assignments as delineated in the Rules and Regulations of the Department to which each Active Staff Member is assigned. Active Staff Members in this category shall be reviewed in the

⁹ 42 CFR §482.12(a)(1)

¹⁰ 42 CFR §482.22(c)(2) and MS 01.01.01 EP 15

OPPE/FPPE process. Members of the Active Medical Staff shall be appointed to a specific Department, shall be eligible to vote, to hold office, and to serve on Medical Staff Committees; and should attend Medical Staff meetings.¹¹ Service Call Obligations of Members may be limited to one or more of the Hospital campus locations (the main campus in Daytona Beach, the campus in Port Orange, or at any future Hospital Emergency Department location) where the Practitioner indicates he/she prefers to perform their Service Call Obligations on their initial application or reapplication for appointment, if such Service Call preference is approved by the Credentials Committee at their discretion and upon recommendation of the appropriate department. Participation in Service Call is a benefit, privilege, and obligation of Active Medical Staff membership. The call obligation shall be determined by the Credentials Committee. If there are an insufficient number of Active Medical staff members who are available or willing to participate in Service Call for one or more Hospital Emergency Department locations, Hospital Administration, in collaboration with the Credentials Committee may elect to outsource the Service Call obligation of a particular department or section for those Hospital Emergency Department locations in order to meet Hospital licensure, regulatory, or legal obligations, without further action by the Medical Staff, and will not be considered an adverse action under these Bylaws. No hearing or appeal rights under these Bylaws are available for any Credentials Committee, Hospital or Medical Staff action or recommendation affecting a Member's Service Call Obligations.

3.3 THE ASSOCIATE STAFF

3.3-1 Requirements for Associate Staff Membership and Consideration for Advancement to Active Staff

The Associate Staff shall consist of initial appointees to the Medical Staff, each of whom is eligible for advancement to Active Staff appointment, but whose status shall not be as full Members of the Active Staff until such advancement occurs. Members of the Associate Staff in all Departments shall be reviewed by the Chair of the Department and any Established Subsection in which clinical privileges are held, in consultation with Active Staff Members of the specific service, in accordance with FPPE policy. The Chair of the Department shall be responsible for determining if there are any deficiencies of performance or other factors, professional or otherwise, present in the performance of the Associate Staff member, which might influence or prevent that individual from obtaining full Active Staff membership at the end of the second year on associate Staff, and shall be responsible for reporting to the Credentials Committee any such findings or deficiencies. The Credentials Committee shall be responsible for considering any deficiencies of performance, or other factors so reported, and if such deficiencies exist, shall be responsible for meeting with the individual, discussing his/her performance with him/her, making him/her aware of such deficiencies and the fact that said deficiencies, if not corrected, could result in failure to obtain Active Staff membership. The Chair of the Department shall be responsible for further close monitoring of the performance of that individual, in accordance with policy.

At the end of one (1) year of Associate Staff membership and FPPE, the Associate Staff member will be eligible for elevation to Active Staff membership. The Credentials Committee shall base its decision upon the recommendation of the Chair of the Department, in

¹¹ 42 CFR §482.22(c)(2), 42 CFR §482.5(b)(2) and MS 01.01.01 EP 15 and EP 17

consultation with Members of any Established Subsection, if necessary, and in consultation with the Hospital. If after being on the Associate Staff for two (2) years the Associate Staff member is not felt to be qualified or suitable for Active Staff membership, such membership shall be recommended for a change to Courtesy Affiliate. In the event the Associate Staff member has not had a sufficient number of cases go through the OPPE/FPPE process before the expiration of two (2) years, reappointment to the Associate Staff may be recommended. In those instances, the Chair of the Department shall make a recommendation to the Credentials Committee as soon as a sufficient number of cases have been completely reviewed.

When non-reappointment is recommended, the reasons for such recommendation shall be stated. A Practitioner may not have his/her Associate Staff membership terminated except by the methods described in these Bylaws.

3.3-2 Obligations for Associate Staff Membership

Each member of the Associate Staff shall discharge the basic obligations of staff Members as required in these Bylaws and any future changes to these Bylaws, the Medical Staff Rules and Regulations, and by directives of the Executive Committee. Each Associate Staff member shall be appointed and assigned to Service Call in the same manner as provided for the Active Staff, and each shall be supervised in accordance with the Rules and Regulations of the Department to which he/she is assigned. Associate Staff Members are not eligible to hold elective office or to vote, except in committees to which they have been assigned.¹²

3.4 SENIOR ACTIVE MEDICAL STAFF

3.4-1 Requirements for Senior Active Medical Staff Membership

The Senior Active Medical Staff shall consist of Members of the Active Medical Staff who have any of the foregoing:

- bona fide physical disability; or
- tenure on the Halifax Medical Center Medical Staff for twenty (20) consecutive years in good standing; or twenty (20) nonconsecutive years in Associate and Active Staff Category, in good standing, with explicit approval by the Credentials Committee and the Governing Body; or
- attained age 65 years with at least ten (10) consecutive years on Active Medical Staff in good standing.

Members of the Active Medical Staff who desire to be classified as members of the Senior Staff may acquire such status by application to the Credentials Committee in the appropriate manner as outlined in these Bylaws, at whatever time they meet the eligibility requirements for such classification. The Practitioner seeking Senior Active Medical Staff status shall provide a copy of said application to his/her Department Chair as well.

A member who has been granted Senior Staff category status because of physical disability shall submit a letter from his/her treating physician annually with his/her application for reappointment each year, such letter to certify that his/her disability continues to qualify him/her for this type of Staff appointment.

¹² 42 CFR §482.22(c)(2)

3.4-2 Obligations for Senior Active Medical Staff Membership

Each member of the Senior Active Medical Staff shall discharge the basic obligations of staff Members as required in these Bylaws and any future changes to these Bylaws, the Medical Staff Rules and Regulations, and by directives of the Credentials Committee. Members of the Senior Staff shall be required to meet the same requirements of Postgraduate Medical Education, payment of Staff dues, attendance at regular Departmental and Staff meetings, and shall be subject to the same rules, regulations and requirements of all other Staff members. Such members shall possess Active voting privileges, and shall be eligible for either elected or appointed office or committee appointments. Members of the Senior Active Medical Staff shall not have the obligation of Service Call unless the Member elects to do so.

3.5 RESIDENT AFFILIATE

The Resident Affiliate Staff shall consist of graduates of recognized medical schools enrolled in accredited medical residency programs (including medical fellowship programs). The Resident Affiliate Staff shall not be eligible to admit patients, to vote or to hold office, but will be eligible for the privilege of the floor for discussion and may be appointed to serve on Medical Staff committees.¹³ No Medical Staff dues will be required. Resident Affiliate Staff Members shall be appointed to a specific Department which pertains to the nature of their residency training or employment. The procedures for suspension, correction or discipline shall not follow the guidelines for the Medical Staff. After completion of, or suspension from a resident training program, Resident Affiliate Staff members will automatically be terminated from their Resident Affiliate Staff membership.

3.6 COURTESY AFFILIATE STAFF

The Courtesy Affiliate Staff consists of Practitioners who have successfully completed a full two year Associate Staff membership, and who by virtue of their specialty, or by the nature of their practice, have limited activity at the Hospital. Courtesy Affiliate Staff members must:

- (i) meet the qualifications specified in these Bylaws for Active or Associate Staff membership;
- (ii) meet all criteria established by the Credentials Committee to confirm that their Hospital practice will be limited; and
- (iii) produce satisfactory quality assurance information concerning their practice.

A Courtesy Affiliate Staff member who exceeds the specified number of patient encounters, as determined by the Credentials Committee and reviewed and ratified by the Medical Executive Committee and the Governing Body shall automatically be returned to the Active Staff category for the remainder of the Practitioner's current appointment.

Courtesy Affiliate Staff members shall be subject to review by the Chair of the services in which clinical privileges are held. Courtesy Affiliate Staff members shall not be required to take Service Call; nor shall they be eligible to vote, to serve as voting members on Committees of the Medical Staff or a Department, or to hold office in the Medical Staff. Time spent as a member of the Courtesy Affiliate Staff shall not count towards tenure on any other Medical Staff membership category.

¹³ 42 CFR §482.22(c)(2) and MS 01.01.01 EP 15

3.7 COMMUNITY AFFILIATE

Community Affiliate Staff shall consist of Practitioners who maintain a clinical practice in the service area of the Hospital and, while not desiring to obtain clinical privileges or to provide hands-on care to their patients in the Hospital, do wish to review medical records of the patients referred by them for admission, follow the patients' progress, confer with the treating physician and observe diagnostic or surgical procedures with approval of the treating physician. Community Affiliate Staff members must:

- meet the qualifications specified in these Bylaws for Active or Associate Staff membership;
 - comply with all Hospital and Medical Staff directives, policies and procedures; and
 - produce satisfactory quality assurance information concerning their practice.
- Community Affiliate Staff shall maintain a valid license to practice medicine in the State of Florida.

Community Affiliate Staff Members may: order non-invasive outpatient diagnostic tests and services for their patients who are not currently undergoing any Hospital care; visit their patients who are undergoing Hospital care and treatment; review the Hospital medical records of their patient; attend Medical Staff and Department meetings; and attend Hospital CME presentations. Community Affiliate Staff Members may not: manage or provide any patient care in the Hospital; make any entries into Hospital medical records; or hold or exercise any clinical privileges at the Hospital.¹⁴

Community Affiliate Staff members shall be subject to review by the Chair of the Department to which the member is assigned by the Credentials Committee. Community Affiliate Staff members shall not be required to take Service Call; nor shall they be eligible to vote on Medical Staff matters, to serve as voting members on Committees of the Medical Staff or Departments, or to serve as officers of the Medical Staff. Time spent as a member of the Community Affiliate Staff shall not count towards tenure on any other Medical Staff membership category.

3.8 COURTESY STAFF

3.8-1 Requirements for Courtesy Staff Membership

The Courtesy Staff consists of Practitioners who practice in a specialty or provide services not readily available on the Medical Staff and who meet the basic qualifications for staff membership, and who only occasionally admit, attend, or provide services for patients in the Hospital. Courtesy Staff members shall maintain a valid license to practice medicine in the State of Florida and maintain active or associate staff medical privileges at an accredited hospital which requires quality assurance activities similar to those at the Hospital.

3.8-2 Obligations of Courtesy Staff Membership

Each member of the Courtesy Staff shall discharge the basic obligations of staff Members as required in these Bylaws and any future changes to these Bylaws, the Medical Staff Rules and Regulations, and by directives of the Credentials Committee. Courtesy Staff Members shall not be required to take Service Call, nor shall they be eligible to vote, to serve as voting Members on Committees of the Staff or Department, or to hold office in the Medical Staff.¹⁵ In the event a Courtesy Staff Member performs more than twenty-four (24) patient contacts in a 12 month period,

¹⁴ 42 CFR §482.22(c)(2) and MS 01.01.01 EP 5

¹⁵ 42 CFR §482.22(c)(2) and MS 01.01.01 EP 5

such Member will be recommended at their next reappointment for Active Staff privileges.

3.9 OUTPATIENT FACILITY STAFF

The Outpatient Facility Staff consists of Practitioners who were members of the medical staff of an outpatient facility, such as an ambulatory surgery center, which was acquired by Halifax Health and who did not have privileges at the Hospital at the time of acquisition. Additionally, Outpatient Facility Staff may include Practitioners who are members of the medical staff of an outpatient facility, such as an ambulatory surgery center, which is operated by and/or owned in whole or in part by Halifax Health, or a Halifax Health affiliate or subsidiary. Outpatient Facility Staff must:

- (i) meet the qualifications specified in these Bylaws for Active or Associate Staff membership;
- (ii) be members in good standing of the staff of the outpatient;
- (iii) produce satisfactory quality assurance information concerning their practice.

Outpatient Facility Staff members shall be subject to review by the Chair of the Department in which clinical privileges are held. Outpatient Facility Staff members shall not be required to take Service Call; nor shall they be eligible to vote, to serve as voting members on Committees of the Medical Staff or a Department, or to hold office in the Medical Staff. Outpatient Facility Staff privileges shall be determined by the Credentials Committee and shall be limited to the outpatient facility at which the Practitioner is a medical staff member. Outpatient Facility Staff members may provide inpatient care only to patients who are admitted in connection with services provided by the Practitioner at the outpatient facility. Time spent as a member of the Outpatient Facility Staff shall not count towards tenure towards any other Medical Staff membership category.

3.10 NON PHYSICIAN PROVIDERS

These provisions shall apply to those individuals who are describes and identified herein as Non Physician Providers (NPP), and whose expertise, skills, talents or activities may be of value to the patient, Medical Staff or Administration of the Hospital.¹⁶ Each applicant's qualifications shall be considered and evaluated by the Credentials Committee as specified herein and shall be credentialed through the same process as a Medical Staff member and shall be granted privileges as either a Dependent or Independent Healthcare Professional.¹⁷ NPP provide direct patient care services in the Hospital under a defined degree of supervision. NPP may attend regular Medical Staff Meetings, but shall not be eligible to vote, to serve as a Medical Staff officer, or serve as Chair of a Medical Staff Committee.

Only those NPP who are certified or licensed, if required by law, to perform their special services in the State of Florida; who maintain or are located in offices within a reasonable distance of the Hospital; who document their background, experience, training, and demonstrate competence in their field, their good reputation and sound moral character and ability to work with others; and who assure the Medical Staff and the Governing Body that any patient served by them will be given a high quality of care in their field, shall be qualified to perform their specified service of function as appropriately credentialed.

¹⁶ F.S. 395.0191, Florida Statutes

¹⁷ F.S. 395.0191 (2)(a) and (c)

3.10-1 Clinical Duties and Prerogatives

NPP may exercise privileges and perform services and duties in the Hospital that have been appropriately credentialed through the process as outlined in these Bylaws. Specifics regarding clinical duties, which are relatively standard for each category and subcategory of NPP shall be delineated in the Rules and Regulations of the Medical Staff, though exception to such may be dictated in the credentials process in specified cases.

3.10-2 Responsibilities

All credentialed NPP shall be responsible for maintaining their competence and, when applicable, their certification and/or licensure in their field of service; adhering to the ethics of their field, demonstrating their ability to work with others in a courteous and pleasant manner; and for the rendering of high quality care to any patient serviced by them in accordance with the Hospital and Medical Staff Bylaws, Rules and Regulations and their credentialed privileges.

All NPP shall be responsible for cooperating with any review of quality assurance function of the Hospital or Medical Staff pertaining to their field of service.

3.10-3 Functions and Limitations of NPP

(i) It is the Physician's responsibility to make it clear to the patient that the patient will be attended by an NPP when applicable.

(ii) The NPP must wear a name tag bearing his/her name and title while performing duties.

(iii) An NPP may perform examinations, treatments and procedures; may write orders and progress notes; and may dictate death summary, operative reports and clinical consultation reports pursuant to the privileges approved by the Credentials Committee and consistent with applicable laws and regulations.

(iv) With the exception of NPP that require the supervision to be formally reported to the Florida Board of Medicine, in the event of the absence of the physician employer, NPP may not function in the Hospital unless supervised by an alternate Physician designated by the Supervising Physician employer. The substitute Physician assumes the responsibility for the NPP during this time period.

(v) An NPP who is classified as an Independent Healthcare Professional is permitted to provide patient care services independently and may perform all or part of the medical history and physical examination, if granted such privileges.

(vi) AN NPP who is classified as a Dependent Healthcare Professional may, as permitted by Florida State law and by the Medical Staff as specified in policy, perform part of all of a patient's medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified physician. The findings, conclusions, and assessment of risk shall be confirmed or endorsed by a qualified physician prior to surgery or other invasive procedure. The specific qualified physician shall retain accountability for the patient's medical history and physical examination.

3.10-4 Protection from Liability

All NPP applicants, by the filing of the initial application for appointment or the filing of any application for reappointment agree and are deemed to agree that in matters relating to appointment, reappointment, termination or reduction of privileges or other "actions" pursuant to this Article III or any other pertinent section of the Medical Staff

Bylaws, that all Members, the Governing Body and all Hospital employees and agents shall be deemed to be acting pursuant to the same rights, privileges, immunities and authorities, including but not limited to the exemption for liability to the NPP affected, as are provided in these Bylaws.

ARTICLE IV- MEMBERSHIP IN THE MEDICAL STAFF

4.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of Halifax Health Medical Center is a privilege, which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws.¹⁸ Every patient shall be admitted by and remain under the care of a member of the Medical Staff. Medical Staff membership is a privilege extended by the Hospital and Governing Body, and not a right of any Physician, Practitioner or other person.

4.2 QUALIFICATIONS FOR MEMBERSHIP¹⁹

Individuals seeking membership on the Medical Staff shall be considered on an individual basis pursuant to criteria applied equally to all other disciplines. Such individuals will complete a pre-application screening process as set forth in these Bylaws. Only those Practitioners and individuals who meet all qualifications as determined by Credentials Services and Medical Staff Leadership will be invited to apply for membership on the Medical Staff.

4.2-1 General Qualifications

Only Practitioners licensed to practice in the State of Florida, who can document their background, experience, training and demonstrated competence,²⁰ health status, their adherence to the ethics of their profession, their good reputation and their ability to work with others, to assure the Medical Staff and the Governing Body that any patient treated by them in the Hospital will be given high quality medical care, shall be qualified for membership on the Medical Staff.²¹ No Practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he/she is duly licensed to practice Medicine, Osteopathy, Dentistry, Podiatry, or Psychology in this or any other State, or that he/she is a member of some professional organization, or that he/she had in the past, or presently has, such privileges at another hospital.²²

All members shall maintain competence in all core privileges, which were established by the relevant Department and were in effect at the time of the member's initial appointment, as a condition of ongoing membership and reappointment.

4.2-2 Specific Qualifications

(a) Physician or Licensed Independent Practitioner applicants for appointment must meet the following criteria:

(i) Medical School Graduate. A new physician applicant must be a graduate of an accredited medical school in the United States or Canada, which has been accredited by the Liaison Committee on Medical Education of the Association of the American Medical Colleges,

¹⁸ 42 CFR §482.22(a)

¹⁹ MS 07.01.01 EP1, EP 2, and EP 4

²⁰ 42 CFR §482.22(a)(2)

²¹ 42 CFR §482.12(a)(6), 42 CFR §482.22(b)(4), and MS 01.01.01 EP13

²² 42 CFR §482.12(a)(7)

or a graduate of a school of Osteopathic Medicine accredited by the American Osteopathic Association, and hold an unrestricted license to practice Medicine or Osteopathy under Florida Statutes Chapter 458 or 459, respectively; and be Board Certified or currently Board Eligible for certification, by a specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association.²³ A new applicant who is a graduate of a foreign medical or osteopathic school must have successfully completed the appropriate examinations required by Florida law, have met the other requirements of postgraduate education for licensure, hold an unrestricted license to practice Medicine or Osteopathy under Florida Statutes Chapters 458 or 459 respectively, and have completed a residency program sufficient to be Board Certified, or currently Board Eligible by a specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association. Dentist applicants requesting surgical privileges must have graduated from an accredited School of Dentistry and be Board Certified or currently Board Eligible by the American Board of Oral Surgery. Podiatrist applicants must have graduated from an accredited School of Podiatry and be Board Certified or currently Board Eligible by the American Board of Podiatric Surgery.

(ii) Board Certification. Once any new applicant is Board Eligible, they must become Board Certified within five (5) years of their initial appointment to the Medical Staff and shall maintain such status throughout their membership, except as provided in these Bylaws. All Practitioners will be required to sign an Attestation Regarding Board Certification at initial appointment and reappointment in which they confirm they have continually maintained their Board Certification. If appropriate, the Governing Body may make an exception to the Board Certification requirement. In the event a Practitioner who is already Board Certified fails to maintain his/her Board Certification, but is otherwise a member in good standing of the Medical Staff in the opinion of the Credentials Committee, the Practitioner will be allowed probationary status (or a grace period) until the next opportunity to re-certify, which must be completed by the next scheduled date offered by the respective Board. If the Practitioner does not re-certify, the Practitioner will no longer continuously meet the qualifications for Medical Staff membership and will automatically relinquish their medical staff membership and privileges. In such event the Practitioner will be notified by the Credentials Committee of such status change, which shall not be considered an adverse action by the Hospital or Medical Staff. Notwithstanding the above, a Member of the Medical Staff in good standing as of (insert date of approval of new bylaws) who does not hold board certification as of that date is exempt from these board certification requirements.

(b) Non Physician Practitioner applicants for appointment must meet the following criteria:

(i) Active Licensure. NPP applicants must be certified or licensed as required by applicable law or regulation in Florida; comply with any physician or practitioner supervision requirements, including maintaining accurate and complete protocols filed with state agencies; and comply with continuing education requirements of their specialty, certifications, or profession.

4.3 CONDITIONS AND DURATION OF APPOINTMENT

Members are appointed to the Halifax Health Medical Staff, but may request that their Service Call Obligations be limited to one or more of the Halifax Health Medical Center or Emergency Department locations (the main hospital location in Daytona Beach, the hospital location in Port Orange, or at any future Halifax Health Medical Center hospital or Emergency Department, or at all Halifax Health Hospital or Emergency Department locations). Initial Applicants and

²³ F.S. 395.0191(3)

Practitioners must designate one or more Hospital campus locations where they prefer to perform their Service Call obligations at the time of initial application or application for reappointment, and such preference may be granted by the Credentials Committee, at their discretion and upon recommendation of the appropriate Department. No hearing or appeal rights under these Bylaws are available for any Credentials Committee, Hospital or Medical Staff action or recommendation affecting a Member's Service Call obligations. Acceptance of membership on the Medical Staff shall constitute the staff member's certification that he/she has in the past, and that he/she will in the future, strictly abide by the Principles of Medical Ethics of the American Medical Association, American Osteopathic Association, American Podiatry Association, American Dental Association, etc., whichever is applicable, and as may be amended from time to time.

Every applicant shall consent to furnish all information concerning his/her prior medical practice and training, and shall hold all persons and institutions furnishing such information in good faith, free and harmless from any and all legal liability or claims or allegations of liability resulting therefrom. By filing his/her application, the applicant further agrees that his/her training, performance, activities and statements at other health care facilities are relevant to the issue of whether he/she should be granted Medical Staff privileges in any category, whether he/she should be elevated from Associate to Active Staff privileges, whether he/she should be granted clinical privileges, whether any of his/her privileges should be revoked, whether any of his/her privileges should be suspended, or whether corrective action should be taken against the applicant. Furthermore, by filing his/her application, the applicant hereby releases and grants a continuing release to the Hospital, any of its Commissioners, officers or employees and all Members, or employees of the Medical Staff who make such inquiries, from any claim or cause of action applicant has or may have arising from such inquiries, and applicant hereby waives any such claim or causes of action related to same, and shall hold the Hospital, its commissioners, officers and employees and the Members and the Medical Staff harmless from any such claims or causes of action.

No appointment or reappointment shall be made for a period which exceeds two (2) years.²⁴ Appointments to the Medical Staff shall confer on the appointee only such clinical privileges as are specified in the notice of appointment in accordance with these Bylaws.

Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligation to provide continuous care and supervision of his/her patients and to abide by the Medical Staff Bylaws, Rules and Regulations.

Notwithstanding any exemption from Service Call established by these Bylaws, all Members, regardless of staff category, may be subject to provide Service Call as deemed necessary by the Credentials Committee, at their discretion and upon recommendation of the appropriate Department. A Member may be relieved of Service Call obligations at one or more Halifax Health Medical Center or Emergency Department location(s) by not selecting that/those location(s) in the initial or reappointment application, by the Credentials Committee, at their discretion and upon recommendation of the appropriate Department, or by action of Hospital Administration pursuant to Section 3.2-2 or Section 4.5-2, herein.

All Members must maintain an unrestricted license to practice their profession in the State of Florida. All Members must maintain continual professional liability insurance, participate in a similar program of self-insurance, or otherwise meet the financial responsibility obligations for licensure where permitted by law or regulation (including the Florida Board of

²⁴ MS 07.01.01 EP 3

Medicine rules for financial responsibility), in the minimum amounts required by law or regulation during the duration of their appointment. In no event shall the limits of a Member's professional liability coverage available to settle a claim or judgment be reduced below said amount. In the event a Member elects to not carry standard professional liability insurance, he/she must provide proof of an appropriate bond, or letter, acceptable to the Credentials Committee and in compliance with Florida law or regulation, at the time the Member no longer has insurance coverage.

4.3-1 Resignation from the Medical Staff

A Member of the Medical Staff may resign his/her appointment and their clinical privileges by submitting a letter of resignation to the Credentials Committee. The letter should include the reasons for the resignation and the effective date. The Chief of Staff and the Credentials Committee shall review the request and forward a recommendation to the Governing Body for final action. If the Member is, at the time of requested resignation, at any stage of corrective action, suspension, hearing or appellate review, then his/her request for resignation shall be deemed a waiver of his/her right to any hearing or appellate review to which he/she might otherwise have been entitled on the matter. The recommendation of the last body to render a decision will then automatically be enforced. When a resignation is accepted or clinical privileges are relinquished during the course of an investigation regarding improper conduct or competence, a report shall be submitted to the Florida Department of Health for reporting to the National Practitioner Data Bank ("NPDB") as required by federal law.²⁵ Resignation may be made contingent upon completion of medical records.

4.3-2 Leave of Absence

Any member of the Medical Staff who is in good standing and who, for any reason, will be unable to carry out his/her responsibilities as a Medical Staff Member must apply for a leave of absence, which will be effective for any time period up to one year. The request must state the beginning date and ending date for the period of leave desired and include the reasons for the request. Application may be submitted to the Chief of Staff and the Credentials Committee, who will rule on the validity of the applicant's request. It will be the responsibility of the Member to provide whatever documentation is necessary to support his/her request for leave of absence, or to renew his/her request. To the extent permissible by applicable law and Hospital policy, a leave of absence shall be limited to one (1) year. Extension of leave of absence beyond this date must be requested by the Staff Member or the Department Chair and approved by the Credentials Committee. Such Members on leave of absence shall be eligible for reactivation of their former credentials status upon return from leave and upon the recommendation of the Department Chair and the Credentials Committee. Time spent on leave of absence shall not be considered in calculating the Member's tenure on the Medical Staff and will not be considered an adverse action or relinquishment of the Member's privileges. During the leave of absence, the Member agrees they may not exercise their privileges nor access Hospital medical records systems, and that their access to these systems will be deactivated during the leave of absence. Upon conclusion of the leave of absence, the Member must contact Credentials Services to request the reactivation of their medical staff status and access to Hospital records systems. If the leave of absence is related to rehabilitation or treatment under the Practitioner Health and Wellbeing Policy, the Member may be required to present documentation of completion of treatment or that any restrictions on their full practice of medicine have been removed, prior to the Member's reactivation of their medical staff status. All qualifications of membership must be current at the time of reactivation of the Member's medical staff status following the leave of absence.

²⁵ 42 CFR §45, CFR 60.9(a)(ii)(A)

4.3-3 Automatic Relinquishment

A Member's appointment and clinical privileges will be automatically relinquished if the Practitioner fails to continually satisfy the Qualifications for Membership during the term of the individual's appointment, without right to a hearing or appeal, if any of the following occur:

- Licensure – revocation, expiration, suspension, or placement of conditions or restrictions on a Practitioner's license;
- Required by contract – if Member has agreed that his/her Medical Staff membership and privileges will be automatically relinquished or otherwise terminate under certain conditions in a contract they have signed with the Hospital or District, and such condition(s) occur;
- Controlled Substance Authorization – revocation, expiration, suspension, or the placement of conditions or restrictions on a Practitioner's DEA registration or state controlled substance authorization;
- Insurance Coverage/Financial Responsibility – expiration or lapse of a Practitioner's professional liability insurance coverage, or other lapse of their compliance with any applicable financial responsibility requirements of the state as a condition of licensure;
- Continuing Education Requirements – failure to complete or report the required number of continuing education hours that are required for active licensure by the state agency granting the Practitioner's license;
- Failure to Provide Requested Information – failure of a Member to provide information pertaining to their meeting the Qualifications for Membership, OPPE/FPPE, professional conduct or rehabilitation conditions or restrictions on the practice of their profession, or compliance with any other Condition under these Bylaws (for reappointment or at any time during their appointment) in response to a written request from the Credentials Committee;
- Medicare and Medicaid Participation – termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state healthcare programs;
- Criminal Activity – indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence.

If any Member shall have his/her medical staff appointment and clinical privileges automatically relinquished for the reasons stated above, the Member shall be informed directly of the nature of the problem and of the automatic relinquishment by personal phone call and by written certified mail, return receipt requested. Such automatic relinquishment shall not be considered an adverse action and will continue until such failure can be remedied or rectified, in compliance with these Bylaws and applicable Medical Staff policies.

4.4 NON-DISCRIMINATION POLICY

No individual shall be denied appointment on the basis of sex, race, creed, religion, color or national origin, or on the basis of any criteria unrelated to the delivery of quality patient care at the Hospital, to professional qualifications or to the Hospital's purposes, needs and capabilities.

4.5 HOSPITAL NEED AND ABILITY TO ACCOMMODATE

No person shall be appointed to the Medical Staff or shall be granted clinical privileges if the Hospital is unable to provide adequate facilities and support services for the applicant or his/her patients. The Hospital Administration or the Governing Body may decline to accept, or have the

Medical Staff review requests for Medical Staff membership and/or particular clinical privileges in connection with appointment, reappointment, the initial granting of clinical privileges, requests for revision of clinical privileges, the renewal of clinical privileges or otherwise on the basis of the following:

4.5-1 Availability of Facilities/Support Services

Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, and capabilities of the Hospital. Prior to granting of a clinical privilege, the resources necessary to support the requested privilege shall be determined to be currently available, or available within a specified time frame. Resource considerations shall include whether there is sufficient space, equipment, staffing, financial resources or other necessary resources to support each requested privilege.

4.5-2 Medical Staff Development Plan

The Hospital Administration and Medical Staff leadership may create a Medical Staff Development Plan to identify the medical staff service needs for current or future campus locations based on strategic initiatives, quality of patient care, financial sustainability, and the patient care needs of the community served by the Hospital. Based on such plan, the Credentials Services may decline to offer medical staff pre-applications to individuals, Practitioners or NPP seeking membership on the Medical Staff.

4.5-3 Effects of Declination

Refusal to accept or review requests for Medical Staff membership or clinical privileges, or to provide pre-applications to individuals, based upon then-existing Hospital or Medical Staff need and ability to accommodate, or a Medical Staff Development plan as described in this Section, shall not constitute a denial of Medical Staff membership or clinical privileges and shall not entitle the individual to any procedural rights of hearing or appeal under these Bylaws.

4.6 PEER REVIEW

4.6-1 Peer Review for Patient Safety

All Members are expected to participate in quality and patient safety reviews and assessments regarding clinical best practices as requested, including but not limited to OPPE and FPPE reviews and other peer review activities, as set forth in these Bylaws and applicable Hospital and Medical Staff policies. The Medical Staff through its Department Chairs and Credentials Committee will work collaboratively with the Hospital Quality Department, Chief Medical Officer, Chief Quality Officer, and Hospital Risk Management to perform the following actions to ensure that high quality standards of clinical competence and patient care are maintained:

- Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general clinical competencies defined by the Medical Staff, in accordance with applicable Hospital and Medical Staff policies (including the Medical Staff Professional Practice Evaluation policy).
- Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to Members and develop plans for improving the quality of clinical care provided;
- Actively be involved in the measurement, assessment, and improvements of activities of Practitioner performance that include but are not limited to a review of the following:

medical assessment and treatment of patient; use of blood and blood components; appropriate use of medications; operative and other procedures; education of patients and families; medical record documentation to include the quality of medical histories; physical examinations and the accuracy, timeliness and legibility of entries; appropriateness of clinical practice patterns; significant departures from established patterns of clinical performance; sentinel event and patient safety data;

- Coordination of care, treatment, and services with other Practitioners and Hospital personnel, as relevant to the care and treatment for an individual patient;
- Review cases and make recommendations for professional improvement, education, monitoring, proctoring, changes in practice, referral for possible rehabilitation or treatment for impairment, and for additional or external review when appropriate for Members;
- Create patient safety work product for submission to Patient Safety Organization;
- Make recommendations to the Credentials Committee for review and any necessary privilege actions.

4.6-2 Professional Conduct and Disciplinary Peer Review

All Members are expected to conduct themselves in a professional, courteous manner at all times, and shall demonstrate appropriate respect to patients, their families and visitors, other Members and Practitioners, and employees of the Hospital. Failure to do so may result in Disciplinary Peer Review or initiation of a Corrective Action or other action as set forth in these Bylaws and applicable Medical Staff or Hospital policies (including the Professional Conduct of Practitioners policy). The Medical Staff through its Department Chairs and the Credentials Committee, will work collaboratively with the Chief Medical Officer, Chief Quality Officer, and Hospital Risk Management to follow the procedures and perform the functions set forth below to ensure that high standards of professional behavior and courtesy are maintained and demonstrated by all Members:

- Conduct a study or investigation, consistent with these Bylaws and Hospital or Medical Staff policies, to determine if the conduct of a Member or Practitioner may constitute one or more grounds for discipline or corrective action;
- A disciplinary peer review study or investigation may be conducted for the following reasons: concerns regarding clinical competence or professional conduct; concerns regarding care or management of a patient or management of a case; known or suspected violation of the Bylaws or policies of the Hospital or the Bylaws or policies of the Medical Staff relating to professional conduct and activities; known or suspected failure to comply with the ethics of his/her profession or the Bylaws of the Hospital or Medical Staff; or behavior or conduct that is considered lower than the standards of the Hospital or Medical Staff, including a significant and recurring inability of a Member or Practitioner to work harmoniously with others;
- A request for a Disciplinary Peer Review may be made by the: Chief of Staff, Chair of any Department or Section; Chief Medical Officer, Chief Executive Officer, Chair of the Governing Body, Chief Quality Officer, or the majority vote of any Hospital or Medical Staff Committee;
- The disciplinary peer review study or investigation will be performed in accordance with applicable Hospital and Medical Staff policies and these Bylaws, and a written report will be prepared to document the allegations, investigation, and any recommendations for necessary actions. Such report(s) shall be maintained by the Chief Medical Officer and the Credentials Committee (through Credentials Services or the Medical Staff office) as part of the Member's file for the duration of the Member's appointment to the Medical Staff;
- A Disciplinary Peer Review Committee may be formed for the purpose of

conducting the above studies and investigations, provided the Committee includes members of the Medical Staff and Hospital Administration.

Where indicated, the Member may also be required to undergo rehabilitation or treatment as set forth in the Practitioner Health and Wellbeing Policy. Any Member undergoing rehabilitation or treatment as a result of actions taken from the Practitioner Health and Wellbeing Policy (or as a result of referral by a licensure/certification board, or on their own initiative) must provide regular documentation to the Credentials Committee of the status of such rehabilitation including any work or practice restrictions on the Member's practice of their profession recommended by the organization providing such rehabilitation or treatment. The Credentials Committee may require the Member to take a leave of absence during such rehabilitation or treatment until the restrictions on their full practice of their profession have been removed.

ARTICLE V- PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT²⁶

5.1 APPOINTMENT AND REAPPOINTMENT²⁷

5.1-1 Application for Clinical Privileges and Medical Staff Membership

(a) Halifax Health follows a pre-application screening process to verify an individuals' qualifications prior to inviting qualified individuals to formally apply for Medical Staff Membership. Invitations to apply for appointment to the Medical Staff shall only be sent to those individuals who have completed the pre-application process and for whom primary source verification has been successfully completed and who are determined to meet the Qualifications for Membership and other requirements of these Bylaws; desire to provide care and treatment to patients for conditions and diseases for which the Hospital has facilities and personnel; meet the clinical and strategic needs of the Hospital or any Hospital location; and indicate an intention to utilize the Hospital as required by the staff category to which they seek appointment.

(b) An individual requesting an initial application for appointment may request a pre-application from Credentials Services, who may send the individual the pre-application process information, including the following: (i) a letter that outlines the Qualifications for Membership and clinical privileges and explains the screening and original (primary) source verification process, (ii) an information release form which must be signed by the individual, and (iii) a pre-application form which requests proof that the threshold criteria for appointment and clinical privileges consideration can be met by the individual. The burden is on the individual to provide complete information for initial appointment. A completed pre-application form with copies of all required documents and any required fees must be returned to Credentials Services within thirty (30) days after receipt of same if the individual desires further consideration. Failure to provide all requested information or fees will result in suspension of further consideration of the individual until such time as the information is provided. Any pre-application form that continues to be incomplete ninety (90) days after the individual has been notified of the additional information required shall be deemed to be withdrawn. Once primary source verification has been completed, the Medical Staff leadership will also review the documentation.

(c) Those individuals who successfully complete the pre-application screening process and Medical Staff leadership review shall be formally invited to apply to become a Member of the Medical Staff. The combined pre-application documents and signed invitation to apply for membership, along with any required fees and recommendations from Medical Staff leadership, shall be considered a complete application for membership and the individual will then be considered an "Applicant" as referenced in Section VIII of these Bylaws herein, and all rights as set forth in Article VIII shall then attach to the Applicant. Individuals who do not successfully complete the pre-application screening process shall not be invited to apply and will be notified of such fact. Failure to be invited to apply to become a Member of the Medical Staff shall not be considered an adverse action and no hearing or appeal rights are available for the individual under these Bylaws, and no reporting to the NPDB or state licensure boards is required.

5.1-2 Required Information

(a) All pre-applications forms shall be approved by the Credentials Committee, and must be signed by the individual. The pre-application process shall be governed by these Bylaws and any applicable policies and procedures of the Medical Staff, Credentials Committee, and/or

²⁶ MS 06.01.03 EP 1 and EP 4

²⁷ MS 01.01.01 EP 27

Credentials Services.

(b) The pre-application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the individual's professional qualifications including, but not limited to the following:

(i) the names and complete addresses of at least three (3) physicians, dentists, podiatrists, psychologists or other individuals, as appropriate, who have had extensive experience in observing and working with the individual, and who can provide adequate information pertaining to the individual's professional competence and character. At least two references must practice in the same specialty area as the individual;

(ii) information as to whether the individual's Medical Staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced or not renewed at any other hospital or healthcare facility;

(iii) information as to whether the individual's license to practice his/her profession in any state, or Drug Enforcement Administration (DEA) license is or has ever been limited, suspended, revoked, or voluntarily relinquished, or if any conditions or restrictions have been placed on the individual's DEA registration or state controlled substance authorization (including a list or copy and verification of all the individual's current licenses to practice, as well as copies of Drug Enforcement Administration license, medical, dental, podiatric or other appropriate graduate school diploma, and certificates from all post graduate training programs completed);

(iv) information as to whether the individual has currently in force professional liability insurance coverage, the name of the insurance company and the amount, classification and expiration of such coverage. Physicians who elect not to carry malpractice insurance must submit proof of continuing compliance with the financial responsibility requirements of the Florida Board of Medicine;

(v) information concerning the individual's professional litigation experience, specifically information concerning pending claims, final judgments or settlements; the substance of the allegations; the findings; the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, Executive Committee, or the Governing Body may deem appropriate;

(vi) information concerning any professional misconduct proceedings and any malpractice actions involving the individual in this state or any other state, whether such proceedings are closed or still pending;

(vii) current information regarding the individual's ability to exercise the privileges requested and to perform the duties and responsibilities of appointment;

(viii) information as to whether the individual has ever been terminated, excluded, or precluded by government action from participation in the Medicare/Medicaid or other federal or state healthcare programs, or has been a named defendant in an insurance or healthcare fraud investigation, litigation, settlement, or verdict;

(ix) information as to whether the individual has ever been indicted, or pled guilty or no contest to any felony, or to any misdemeanor involving controlled substances, illegal drugs, insurance or healthcare fraud or abuse, or violence, with details about any such instance;

(x) a complete chronological listing of the individual's professional and educational appointments, employment, or positions;

(xi) an attestation of US citizenship, or documentation evidencing that the individual is in the US lawfully and permitted to work in the profession for which privileges are

requested;

(xii) the individual's signature; and

(xiii) an attestation of Board Certification or Board Eligibility and such other information as the Governing Body may require.

(c) The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as criterion for appointment, reappointment, and the granting of clinical privileges. However, the mere presence of verdicts, settlements or claims shall not, in and of themselves, be sufficient to deny appointment or particular clinical privileges. The evaluation shall consider the extent to which verdicts, settlements or claims evidence a pattern of care that raises questions concerning the individual's clinical competence, or whether a verdict, settlement or claim in and of itself, represents such deviation from standard medical practice as to raise overall questions regarding the individual's clinical competence, skill in the particular clinical privilege, or general behavior.

(d) A pre-application shall not be deemed to be complete until such time as the Practitioner produces all information as required in the pre-application form and this Section. Credentials Services shall collect and evaluate all reference information and other documents and materials from any and all sources deemed pertinent, and contact any of those institutions in which the individual received medical education or training to determine accuracy and completeness of facts disclosed along with any other relevant information. Individuals who provided references or recommendations, or other individuals with relevant information, shall also be contacted regarding the individual seeking appointment's professional competence and ethical character. Credentials Services will maintain clear documentation of these activities and inquiries, with such documentation being considered part of a completed pre-application for membership.

5.1-3 Basic Responsibilities, Releases and Consents

The following basic responsibilities, releases, and consents shall be applicable to every individual participating in the pre-application process, every Applicant and/or Practitioner seeking Medical Staff appointment or reappointment as a condition of consideration of such application and as a condition of continuing Medical Staff appointment if granted:

(a) An obligation to provide appropriate continuous and timely care and supervision to all patients in the Hospital for whom the individual, Applicant or Practitioner has responsibility;

(b) An agreement to abide by all bylaws and policies of the Hospital, including these Bylaws of the Medical Staff and Medical Staff policies and procedures as shall be in force during the time the individual, Applicant or Practitioner is appointed to the Medical Staff;

(c) An agreement to accept committee assignments and such other reasonable duties and responsibilities as may be appropriate;

(d) An agreement to provide to the Hospital, with or without request, and, as it occurs, new or updated information that is pertinent to any question on the application form, including but not limited to loss of his/her right to participate in federal healthcare programs;

(e) A statement that the individual, Applicant or Practitioner has received and had an opportunity to read a copy of these Medical Staff Bylaws, and Rules and Regulations of the Medical Staff as are in force at the time of application, and that the individual has agreed to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment to the Medical Staff and/or clinical privileges are granted;

(f) A statement of the individual, Applicant, or Practitioner's willingness to appear for personal interviews in regard to the pre-application or credentialing process;

(g) An agreement that the hearing and appeal procedures set forth for Applicants and Members in these Bylaws shall be the sole and exclusive remedy with respect to any adverse action taken on clinical privileges at this Hospital;

(h) An obligation to authorize the release of all information necessary for an evaluation of the individual, Applicant or Practitioner's qualifications for initial or continued appointment, reappointment, and/or clinical privileges;

(i) A willingness to appear for interview by the Credentials Committee in regard to his/her pre-application or formal application, and a grant of authorization to and consent for the Hospital and members of appropriate Hospital committees to consult with members of the medical staffs of other hospitals with which the individual has been associated and with others who may have information bearing on the clinical competence, character, ability to work with others or on the individual's moral and ethical standards. Further, the individual, Applicant or Practitioner consents to the Hospital and members of appropriate Hospital and Medical Staff committees inspecting all records and documents that may be material to an evaluation of the individual's professional qualifications and competence to carry out the clinical privileges requested, as well as material to evaluating the individual's ability to work well in the Hospital with others and the individual's moral and ethical qualifications for Medical Staff membership;

(j) The individual, Applicant or Practitioner seeking initial appointment or reappointment specifically releases from any liability all representatives of the Hospital and its Medical Staff, Credentials Committee, Governing Body, and all individuals acting by or on behalf of those entities or individuals for all acts or omissions performed in good faith in connection with evaluating the individual's credentials, and releases from any liability all persons and organizations who provide information to the Hospital concerning the individual, Applicant or Practitioner's competence, ethics, character and other qualifications for Staff appointment and clinical privileges. The individual, Applicant or Practitioner shall also sign forms evidencing his/her consent and release of liability as required by Credential Services or the Credentials Committee so that these forms may be provided to external individuals or entities as part of the original source verification and credentialing process; and

(k) An agreement to extend absolute immunity to the Hospital, its Medical Staff, Credentials Committee, Governing Body, and all individuals acting by or on behalf of those entities or individuals for all acts or omissions taken in good faith relating to evaluation and assessment of the individual, Applicant, Practitioner, or Member's ongoing compliance with the Qualifications of Membership and other Conditions of Membership and these Bylaws.

5.1-4 Medical Staff Leadership Review and Invitation to Apply

(a) After receipt of the properly completed pre-application and accompanying documentation, Credential Services will advise the CMO and shall forward the pre-application and attached documents and forms to the Chairs of all Departments in which the individual seeks clinical privileges for use in the evaluation and appraisal of the individual by such Chairs in order to make the required recommendations to the Credentials Committee regarding the individual's clinical privileges. As soon as practicable but within thirty (30) days of receipt of such application and documents, the Chair of each appropriate Department shall submit his/her recommendations regarding whether the individual meets the underlying qualifications for the requested, in writing, to the CMO, and such recommendations shall become a part of the completed pre-application. Chairs of the Departments should consider only the individual's information and pre-application in good faith and without regard to any personal or financial conflicts of interest, or the individual's potential business competition or contract(s) with the Hospital or a Hospital affiliate or subsidiary.

(b) After receipt of each clinical Department's recommendations, the CMO (or the

CMOs designee) shall confirm that the individual should be either invited to apply for membership on the Medical Staff and ensure the formal application is provided to the candidate, or will notify the individual that he/she will not be invited to formally apply for membership on the Medical Staff. If the individual formally applies for membership and pays any required fees, his/her application for membership to the Medical Staff shall be deemed complete and the candidate is then considered and “Applicant” as referenced in Article VIII herein, and all rights as set forth in Article VIII shall then attach to applicant. Credentials Services shall then deliver the completed application to the Chair of the Credentials Committee with the advice that such Application and inquiry is complete and ready for the consideration and recommendation of the Credentials Committee.

5.1-5 Miscellaneous Provisions

A Practitioner may not be appointed to the Medical Staff or be granted clinical privileges other than by the process described in Article V and Article VI of these Bylaws.

5.2 APPOINTMENT PROCESS

5.2-1 Appointment Recommendations

The Credentials Committee, on behalf of the Executive Committee, shall make a written report of its recommendations concerning an Applicant to the Governing Body through the Chief Executive Officer of the Hospital or his/her designee and the Chief of Staff. Prior to making this report, the Credentials Committee shall examine the appropriate character, professional competence, qualifications, ethical standing, and ability to work in the Hospital efficiently and harmoniously with others. The Credentials Committee shall evaluate the moral, emotional, physical and mental status of the Applicant. Should there be any inadequacies in these categories, appointment will not be recommended to the Governing Body. The Credentials Committee shall evaluate the information contained in references given by the Applicant and other matters contained in the completed application, including the recommendations of each Clinical Department in which privileges are sought, all to determine whether the Applicant meets all of the necessary qualifications for the category of Staff membership and the clinical privileges requested. The Credentials Committee should consider the Applicant’s application and information in good faith and without regard to any personal or financial conflicts of interest, or the Applicant’s potential business competition or contract(s) with the Hospital or a Hospital affiliate or subsidiary.

Within thirty (30) days of its consideration of the completed application, or as soon as possible given the meeting schedule of the Governing Body, the Credentials Committee or CEO shall transmit to the Governing Body its written recommendation that the Applicant(s) be either appointed to the Medical Staff or rejected for Medical Staff membership; and, as to the requested clinical privileges, whether to grant or deny those privileges recommended by the Credentials Committee only; or that the application for membership or certain clinical privileges or both be deferred for further consideration. When the recommendation of the Credentials Committee is adverse to the Applicant with respect to either Medical Staff membership or clinical privileges, the Governing Body may request further information prior to making a final decision on whether the Applicant should be appointed or reappointed to the Medical Staff. The CEO, through the Credentials Committee or its designee, shall promptly provide such information to the Governing Body. At the time of the Governing Body’s final decision on whether to appoint, reappoint, or reject membership on the Medical Staff for an Applicant, the CEO, through the Credentials Committee or its designee, shall give written notice to the Applicant by Certified Mail, return receipt requested. In the instance where the certified mail receipt is not returned by the addressee the notification will be forwarded by

Overnight Mail. Such notice must be consistent with the “Notice” provisions in these Bylaws.

5.2-2 Decision by Governing Body

The Governing Body's decision with respect to granting or denying initial applications for Medical Staff membership and clinical privileges shall be according to the procedures and requirements of these Bylaws. Applicants may be asked to appear before the Governing Body to introduce themselves, but the Governing Body may act upon the recommendations of the Credentials Committee and may reject initial applications or approve initial applications and grant appointment to the Medical Staff and privileges without the necessity of a personal appearance by any Applicant at a meeting of the Governing Body. When the Governing Body's decision is final, it shall send notice of such decision through the CEO to the Secretary/Treasurer of the Medical Staff, the Chief of Staff, the Chair of the Credentials Committee and the Chair of the Department concerned, and to the Applicant.

5.3 REAPPOINTMENT PROCESS

5.3-1 Application for Reappointment

Each Medical Staff Member who is eligible to be reappointed to the Medical Staff shall be responsible for timely completion of the reappointment application form. The application shall be submitted to Credential Services according to the requirements of the Credential Services policy or process, which shall be communicated to all Members seeking reappointment. The Member may be required to provide documentation or attestations regarding the Required Information set forth in Section 5.1-2, as required by Credential Services, to demonstrate that the Member continues to meet all Qualifications for Membership and the Conditions set forth in these Bylaws. Reappointment, if granted, shall be for a period of not more than two (2) years. If no reappointment application is received, Credential Services may attempt to contact the Member to determine whether the Member intends to reapply. However, it remains the Member's responsibility to submit a timely application for reappointment. If no reappointment application is received after attempted contact this will be considered a voluntary relinquishment of privileges and the Practitioner will need to reapply.

5.3-2 Recommendation by Credentials Committee

(a) The Credentials Committee, on behalf of the Executive Committee, shall complete its review of all pertinent information available on each Member scheduled for periodic appraisal, for the purpose of determining its recommendations for reappointments to the Medical Staff, and for the delineation and granting of clinical privileges to Applicants for the ensuing period. The Credentials Committee will consider any Corrective Action or other informal process related to professional conduct of the Member, as well as any outstanding or unresolved OPPE/FPPE issues identified by the Halifax Quality Department for the Member. The CMO or Credential Services shall request any relevant information on such conduct or OPPE/FPPE issues for a Member seeking reappointment from the Halifax Quality Department or any other department or entity which may have such information in advance, so that any relevant information may be considered by the Credentials Committee prior to making a recommendation.

(b) Each recommendation concerning the reappointment of a Medical Staff Member and the clinical privileges to be granted upon reappointment shall be based upon such Member's professional competence and clinical judgment in the treatment of patients, ethics and conduct in accordance and compliance with the Code of Medical Ethics as adopted by the American Medical Association, active participation in continuing postgraduate medical education, compliance with the

Hospital policies, the Medical Staff Bylaws, Rules and Regulations and the Governing Body's Bylaws, rules regulations and resolutions and policies. The moral, emotional, physical and mental status of each Practitioner and their ability to work efficiently and harmoniously with others in a hospital setting shall be considered, and failure to meet the usual accepted standards in any or all categories shall be adequate grounds for denial of the reappointment of the Member.

(c) The Credentials Committee, on behalf of the Medical Executive Committee, shall make written recommendations to the Governing Body through the CEO or Chief of Staff concerning the reappointment or non-reappointment of each member of the Medical Staff, including the specific clinical privileges to be granted to each reappointed Member for the ensuing period. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented, but this shall not require that each incident of similar action or behavior be specifically stated and documented as long as the recommendation is sufficient to give notice of the type of action or behavior upon which the adverse recommendation is based. Recommendations for non-reappointment or for a lessening or limiting of clinical privileges shall not be sent to the Governing Body until the Practitioner has waived or exhausted fair hearing rights specified in these Bylaws.

- If the recommendation is favorable to the Member, the procedure provided above, relating to recommendations on applications for reappointment shall be followed. If the recommendation is adverse to the Member, the Member shall be entitled to the rights and procedures, as specified in Article VIII of these Bylaws.

- While considering a Member's reappointment the Credentials Committee, the Governing Body, the CEO and their representatives shall be entitled to the same rights and authority as are conferred upon them in connection with the consideration of an initial application for appointment to the Medical Staff, and shall be entitled to consider all the matters set forth in the preceding subsections with respect to the Member's activities at other hospitals and the Member's medical practice outside the Hospital. Specifically, the applicant for reappointment is bound by the same obligation to provide consents and releases of liability to those entities and individuals involved in the reappointment process as set forth in Section 5.1-3(i) above.

5.3-3 Reapplication Upon Denial

A Member of the Associate Staff who has served on the Associate Staff for two (2) years, and who has been deemed unqualified for elevation to Active Staff and denied reappointment may not apply for membership on the Medical Staff for a period of twelve (12) months from the date of final action on his/her application. At the end of a twelve (12) month period of time following denial of reappointment, such individual may request an application and reapply for membership to the Associate Staff of the Hospital as outlined in these Bylaws for any new individual.

5.4 EXPEDITED PROCESS

The Credentials Committee may develop, and the Governing Body may approve, an expedited approval process to be used when the full Governing Body may not meet during a particular month, or for other situations when hardship to the Practitioner or Hospital may occur if approval of credentials as recommended by the Credentials Committee is delayed until a meeting of the full Governing Body. Such expedited process must be consistent with the applicable laws, regulations, accreditation standards, Enabling Act and the Bylaws of the Governing Body, and must be approved by the Governing Body.

ARTICLE VI - CLINICAL PRIVILEGES

6.1 GENERAL PROVISIONS²⁸

Every Practitioner practicing at the Hospital, including the practice of telemedicine, by virtue of Medical Staff membership shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to the Practitioner by the Governing Body, except as otherwise provided in these Bylaws.²⁹

The privileges must be specific, within the scope of the license authorizing the individual to practice in this state or any certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, within the scope of the individual's current competence, and shall be subject to the Rules and Regulations of the Department, and shall be granted for a period not to exceed two (2) years.³⁰ Clinical privileges may be granted, continued, modified, or terminated by the Governing Body upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outline in these Bylaws. Each Practitioner must obtain consultation with another Practitioner who possesses appropriate clinical privileges in any case when the clinical needs of the patient exceed the clinical privileges of the Practitioner(s) currently attending the patient. Additionally, consultation must be obtained when required by these Bylaws, the Medical Staff and Department Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation.

A completed application for Medical Staff appointment or reappointment must contain a request for all clinical privileges desired by the Applicant.³¹ The evaluation of such requests shall be based upon the Applicant's education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the Clinical Department in which such privileges are sought. The Applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges requested. Clinical privileges must be delineated for every Practitioner by each service, including Members in any category of Medical Staff status (**Note there are no clinical privileges associated with honorary or community affiliate members). These privileges must be stated in a precise manner, and be hospital-specific. The process to disseminate all granting, modification, or restriction decisions shall be approved by the Medical Staff.³²

To have prescribing privileges for controlled substances, the Practitioner must possess a current Federal Drug Enforcement Administration (DEA) registration and any required state authorization or registration, or for NPP, must continually meet the conditions of all state laws and regulations which authorize prescribing privileges for NPP. NPP shall only have those prescribing privileges for controlled substances specifically authorized in state law and regulations. Prescribing privileges shall be limited to the classes of drugs granted to the Practitioner by the DEA and applicable law, and may be further limited by the Medical Staff through the delineation of medication prescribing privileges based on the scope of practice and current competence of the Practitioner.

In case of an emergency situation, any Practitioner, to the degree permitted by his/her license and regardless of service, or Staff status or lack thereof, shall be permitted to do and

²⁸ MS 06.01.05 EP 4

²⁹ MS 06.01.07 EP 8

³⁰ MS 06.01.07 EP 9

³¹ MS 01.01.01 EP 14

³² MS 05.01.09 EP 4

assist in doing everything possible to save the life of a patient, using every facility of the Hospital necessary, including calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Practitioner must request the privileges necessary to continue to provide those services to the patient. In the event such privileges are denied or the Practitioner does not desire to request such privileges, the patient shall be assigned to another appropriate Member of the Medical Staff. For the purposes of this Section, an "emergency situation" is defined as a situation in which serious permanent harm would result to a patient, or the life of a patient would be placed in immediate danger in the absence of immediate medical care.

6.1-1 Admitting Privileges

Only Members with clinical privileges or qualified Practitioners granted temporary privileges may be granted admitting privileges. The privilege to admit shall be delineated, and is not automatic.

6.1-2 Medical History and Physical Examination Requirements³³

Clinical privileges for performing a medical history and physical examination shall be delineated. The medical history and physical examination shall be completed and documented by a qualified physician, oral/maxillofacial surgeon, or other qualified licensed Practitioner in accordance with State law and Hospital policy. A medical history and physical examination shall be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but always prior to surgery or a procedure requiring anesthesia services. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physician examination are completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a qualified physician, oral/maxillofacial surgeon, or other qualified licensed Practitioner in accordance with State law and Hospital policy.

6.2 ADDITIONS TO CLINICAL PRIVILEGES

A request by a Member with clinical privileges for additional clinical privileges or modifications in clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. In processing such a request, the NPDB shall be queried,³⁴ the Practitioner's Florida license status and financial responsibility compliance shall be queried, and the response used by the Medical Staff and the Governing Body in considering the request. The following documentation shall be included with any requests for an increase in clinical privileges and new clinical privileges:

- Training, continuing education, and experience related to the new clinical privileges requested shall be verified.
- Evidence of current competence related to the new clinical privileges requested shall be verified with current supporting documentation.
- Information provided by peers of the Practitioner shall be included in deliberations when increasing privileges.

³³ 42 CFR §482.22(c)(5)(i) and (ii) and MS 01.01.01 EP 16

³⁴ MS 06.01.05 EP 7

Practitioners are required to report malpractice insurance coverage information for the new privileges requested.

When revising clinical privileges, the Practitioner shall be required to respond to queries regarding whether there have been any:

- Previously successful or currently pending challenges, or voluntary relinquishment, of licensure or registration.
- Voluntary or involuntary reduction in privileges or termination of privileges or membership.
- Involvement in any liability actions, including any final judgments or settlements.

6.3 BASIS FOR PRIVILEGE DETERMINATION³⁵

There shall be criteria for granting, renewing or revising clinical privileges that are directly related to the quality of healthcare and pertain to the evidence of current competence and ability to perform the privileges requested.³⁶ Applications and requests for clinical privileges shall be evaluated on the basis of the Practitioner's education, training, current competence, the ability to perform the clinical privileges requested, professional references, information from the Practitioner's current or past facility affiliations, professional liability experience and insurance coverage, and other relevant information, including an evaluation by the Chair of the Clinical Department in which the privileges have been sought. The criteria for granting clinical privileges shall also include the ability of the Hospital to provide supportive services for the Practitioner and his/her patients. Clinical privileges that are granted, renewed, or revised shall be setting-specific, meaning that in approving privileges, considerations shall include not only the Practitioner's qualifications but also the availability of equipment, the number, type and qualifications of staff, and/or the appropriateness of the physical environment and resources in a particular Hospital setting. Clinical privileges may be restricted by the Governing Body to only certain settings within the Hospital, as appropriate to each setting.

Additionally, all Practitioners with delineated clinical privileges are required to participate in continuing education as related to their privileges, and the Practitioner's participation in continuing shall be considered when renewing or revising such privileges. Before clinical privileges are granted, renewed, or revised by the Governing Body, the Medical Staff and Credentials Committee shall evaluate each Practitioner with regard to the following information and make a recommendation based on the following information:

- For Practitioners in fields performing operative and other procedures, the types of operative procedures performed as the surgeon of record, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information about appropriateness and outcomes of the procedures;
 - For Practitioners in non-surgical fields, the types and outcomes of medical conditions managed by the Practitioner as the responsible physician;
 - The Practitioner's clinical judgment and technical skills;
 - Any evidence of unusual patterns of, or an excessive number of, professional liability actions resulting in a final judgment against the Practitioner;

³⁵ MS 06.01.05 EP 2, EP 3, EP 9 and EP 10 and MS 06.01.07 EP 2 and EP 3

³⁶ 42 CFR §482.22(c)(6); MS 06.01.07 EP 6

- Information from quality assessment and performance improvement, including but not limited to review of operative and other procedures, use of blood products, use of medications, review of medical records, utilization management/medical necessity review, risk management data, and patient safety data;

- Relevant Practitioner-specific data that are compared to aggregate data;
- Morbidity and mortality data, when available.

Additionally, in considering any request to grant, continue, modify, or increase clinical privileges, the Hospital, including any committee of the Medical Staff, or the Governing Body may, in its discretion, obtain assistance with their evaluation.

6.4 DELINEATION³⁷

Requests for clinical privileges shall be processed pursuant to the procedures outlined in these Bylaws. Clinical privileges shall be delineated on an individual basis. In evaluating a Practitioner who requests renewal or revision of clinical privileges, the evaluation shall include ensuring that the Practitioner does not practice outside the scope of privileges granted, and information about the Practitioner's change in scope of practice shall be reflected when updated privilege delineation is made, and only approved privileges that are within the scope of practice shall be permitted. The delineation of a Practitioner's privileges shall include the limitations, if any, on the Practitioner's privileges to admit or treat patients or direct the course of treatment of the patients who have been admitted.

6.5 TELEMEDICINE PRIVILEGES³⁸

Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff Member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws.³⁹ The Medical Staff shall define in the Rules and Regulations or Medical Staff policy which clinical services are appropriately delivered through telemedicine medium, according to commonly accepted quality standards.⁴⁰ Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner shall be encompassed in clinical privileging decision. Controlled substances may not be prescribed through the use of telemedicine.⁴¹

When telemedicine services are furnished to the Hospital's patients through an agreement with a distant-site hospital, after approval by the Credentials Committee, the Governing Body of the Hospital whose patients are receiving the telemedicine services may choose to have the Medical Staff rely upon the credentialing and privileging decisions may by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the Hospital's Governing Body ensures, through its written agreement with the distant-site hospital, that all of the following provisions are met:⁴²

³⁷ MS 06.01.05 EP 12 and MS 06.01.07 EP 1

³⁸ MS 13.01.01 and MS 13.01.03

³⁹ 42 CFR §482.22(c)(6)

⁴⁰ MS 13.01.03 EP 1 and EP 2

⁴¹ F.A.C. 64B-9.0141 and F.A.C. 64B15-14.0081

⁴² 42 CFR §482.22(a)(3) and (4) and 42 CFR §482.12(a)(8) and (9)

(i) The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.

(ii) The individual distant-site physician or practitioner is board certified and privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital.

(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State of Florida in which the hospital whose patients are receiving the telemedicine services is located.

(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the Hospital whose patients are receiving the telemedicine services, the Hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the Hospital's patient and all complaints the Hospital has received about the distant-site physician or practitioner.

(v) The distant-site telemedicine entity furnishes services that permit the Hospital to comply with all applicable conditions of participation for the contracted services.⁴³

(vi) The distant-site telemedicine entity's Medical Staff credentialing and privileging process and standards at least meet the standards set by Hospital and as required by applicable law and accreditation standards.⁴⁴

(vii) It is the responsibility of the governing body of the distant-site hospital to meet the requirements with regard to the distant-site hospital's physicians and practitioners providing telemedicine services.⁴⁵ The Governing Body of the Hospital whose patients are receiving services may grant privileges based on its Medical Staff recommendations that rely on information provided by the distant-site hospital.⁴⁶

(viii) The distant-site telemedicine entity is a contractor of services to the Hospital and as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable Conditions of Participation for the contracted services with regard to the distant-site telemedicine entity's physicians and practitioners providing telemedicine services.⁴⁷ The Governing Body of the Hospital whose patient are receiving the telemedicine services may grant privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital's Medical Staff recommendations; such staff recommendations may rely on information provided by the distant-site telemedicine entity.⁴⁸

6.6 USE OF ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS, PODIATRISTS AND DENTISTS/ORAL SURGEONS

A physician, psychologist, podiatrist, chiropractor, dentist or oral surgeon, who is not a Member and who has not been granted clinical privileges may order outpatient ancillary services and the Hospital may occasionally accept and execute orders for outpatient ancillary services from Non-Privileged Practitioners who are not Members and who have not been granted any clinical

⁴³ 42 CFR §482.12(e)

⁴⁴ 42 CFR §482.12(a)(1)-(a)(7) and 42 CFR §482.22(a)(1)-(a)(2)

⁴⁵ 42 CFR §482.12(a)(1)-(a)(7)

⁴⁶ 42 CFR §482.22(a)(3)

⁴⁷ 42 CFR §482.12(e) and 42 CFR §482.12(a)(1)-(a)(7)

⁴⁸ 42 CFR §482.22(a)(4)

privileges at the Hospital, at the Hospital's discretion, provided there is a Member of the Medical Staff with appropriate privileges willing to perform such service. Such orders from Non-Privileged Practitioners will be carried out at Hospital facilities only if all the following conditions are met in advance:

- The Non-Privileged Practitioner shall provide proof of current licensure within this State, which shall be verified by the Hospital prior to acceptance and execution of the order for services;
- If medications are being ordered that require the Non-Privileged Practitioner to hold a DEA registration, such Non-Privileged Practitioner shall provide proof of current, unrestricted DEA registration.
- The Hospital shall ensure that the Non-Privileged Practitioner is eligible to participate in federal and state health programs by checking the OIG Sanction Report and the GSA List at the time of ordering tests or services and at least every six months thereafter.
- The Non-Privileged Practitioner shall be limited to ordering only those tests or services that are within the scope of his/her license to order as established by Florida State law. The orders shall be confined to those for outpatient laboratory, non-invasive radiology, rehabilitation services (including physical therapy, occupational therapy, and speech therapy), diagnostic cardiopulmonary or electro diagnostic testing, or medications.
- The order of the Non-Privileged Practitioner can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering Non-Privileged Practitioner, and the Non-Privileged Practitioner may not bill any professional fees related to the performance of the order for services at the Hospital.
- The ordering Non-Privileged Practitioner does not hold himself/herself to be associated or affiliated with the Hospital or its Medical Staff.
- The Non-Privileged Practitioner's ordering practices shall be subject to the supervision of the Chair of the Hospital Department performing the test or services, the CMO, or the Chief of Staff. The Non-Privileged Practitioner's ordering practices shall be subject to a review for medical appropriateness and necessity by the Member of the Medical Staff who will provide the services ordered, or the CMO or Chair of the Hospital Department which would perform the services ordered, any of whom may decline to perform the order or service if they have any clinical or quality concerns. Orders from a Non-Privileged Practitioner that lack evidence of medical appropriateness or necessity shall not be performed and the Non-Privileged Practitioner shall be notified immediately to be given the opportunity to clarify/justify the order.
- All diagnostic tests that require an interpretation by a Medical Staff Member with a delineated clinical privilege to do so shall be subject to interpretation by a Member of the Medical Staff with such privileges, the Chair of the Department which would perform the services ordered, or the CMO, and the interpretation shall be provided to the Non-Privileged Practitioner.

6.7 LIMITED LICENSURE PRACTITIONERS

Requests for clinical privileges from a limited licensure Practitioner (e.g. Licensed Independent Practitioners (LIP)) shall be processed in the manner and based on the same conditions as for any Applicant for clinical privileges. Patients admitted by a limited licensure Practitioner with admitting privileges shall be under the care of a physician Member of the Medical Staff with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting Practitioner. All patients admitted by a limited licensure Practitioner shall be responsible for securing the services of such physician Member of the

Medical Staff prior to the admission of the patient and shall supply the name of the physician to the Hospital. The limited licensure Practitioner shall be responsible for performing the part of the history and physical examination related to the care he/she will provide:

- Dentists are responsible for the part of their patient's history and physical examination that relates to dentistry.
- Podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry and, if granted clinical privileges, may perform a full medical history and physical to provide medical clearance on uncomplicated patients. In order to request these privileges, podiatrists must provide documentation of training and competence in performing full medical history and physicals. If the patient is medically complex, the medical clearance examination and clearance for surgery must be performed by a Physician.
- An oral and maxillofacial surgeon who has successfully completed a post graduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the US Department of Education, and who has been determined by the Medical Staff to be currently competent to perform a history and physical examination, may be granted the clinical privilege to perform the medical history and physical examination.
- Other LIP who are permitted to provide patient care services independently may perform all or part of the medical history and physical examination, if granted such privileges. The findings, conclusions, and assessment of risk shall be confirmed or endorsed by a qualified physician prior to major high-risk (as defined by the Medical Staff in the Rules and Regulations or policy) diagnostic or therapeutic interventions.
- In addition, as permitted by Florida State law and by the Medical Staff as specified in policy, Practitioners who are not LIP may perform part or all of a patient's medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified physician. The specific qualified physician shall retain accountability for the patient's medical history and physical examination.

6.8 UNAVAILABLE CLINICAL PRIVILEGES

Notwithstanding any other provisions of these Bylaws, to the extent that any requested clinical privilege is not available at the Hospital, the request shall be denied. Because such a denial of clinical privileges is unrelated to the Practitioner's qualifications or competence, a Practitioner whose request is so denied shall not be entitled to the Fair Hearing and Appeal rights under these Bylaws and is not subject to reporting to the NPDB via the state professional licensure agency.

6.9 TEMPORARY PRIVILEGES⁴⁹

6.9-1 Circumstances

Temporary privileges may be granted to meet an important patient care need for a limited time or while awaiting final approval of the Governing Body of the Applicant's Membership on the Medical Staff. The CEO or designee, Chief Medical Officer, Chief of Staff, and the Chair of the applicable Department, or their respective designees, may, upon the basis of a completed application which can be relied upon as to the competence and ethical standing of the Practitioner, grant temporary Medical Staff Membership, which may include admitting and clinical privileges, to the Practitioner, for a maximum, non-renewable period of one hundred twenty (120) days. In

⁴⁹ MS 06.01.13

exercising such privileges the Practitioner shall act under the supervision of the Chair of the Department to which the Practitioner is assigned.

Temporary clinical privileges for the care of a specific patient may be granted by the CEO to a Practitioner who is not an Applicant in the same manner and upon the same conditions set forth in the paragraph immediately above, provided the CEO or designee first is in receipt of such Practitioner's signed acknowledgment that the Practitioner has received and read copies of the Hospital's Bylaws and Medical Staff Bylaws, Rules and Regulations, and that the Practitioner agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges. Such temporary privileges shall be restricted to the treatment of not more than ten patients in any one year by any Practitioner, after which such Practitioner shall be required to apply for temporary privileges under this Section, shall be Board Certified in their field of medicine, and shall maintain such Board Certified status for the duration of their temporary privileges.

6.9-2 Locum Tenens Practitioners

The Governing Body, upon the recommendation of the CEO or designee, may permit a Practitioner to serve in a locum tenens capacity and to attend patients without applying for formal membership on the Medical Staff, for a period not to exceed one hundred twenty (120) days of actual service, provided that such Practitioner has completed locum tenens application for privileges has been received and requested clinical privileges have been approved by the CMO, the Chief of Staff or designee, Chief Operating Officer (COO) or designee, and the appropriate Department Chair. Moreover, the Practitioner must certify that he/she has received and read copies of the Hospital's Bylaws and Medical Staff Bylaws, Rules and Regulations, and that the Practitioner agrees to be bound by the terms thereof in all matters relating to his/her locum tenens privileges. In all cases for locum tenens, the following will be verified: Florida licensure, Board Certification, DEA registration (if applicable), professional liability coverage, current hospital affiliations, NPDB information, and Office of Inspector General information. In the event that the Hospital has entered into a written agreement with an entity to provide locum tenens practitioners to the Hospital, such entity shall bear the responsibility of obtaining and maintaining temporary privileges for those locum tenens Practitioners that such locum tenens Practitioners provide to the Hospital. Other than locum tenens Practitioners provided through a written agreement between the Hospital and a physician staffing entity, no Practitioner may be credentialed under this provision as a locum tenens Practitioner for a period exceeding one (1) year. After that time, the Practitioner may apply for the appropriate active medical staff privileges.

6.9-3 Special Conditions of Supervision

Special conditions of supervision and reporting may be imposed by the appropriate Departmental Chair on any Practitioner holding temporary privileges. A Practitioner holding temporary privileges has no right to a hearing with respect to such conditions. Upon recommendation of the Credentials Committee and the Chair of the Department concerned, temporary privileges shall be immediately terminated upon notice of any failure by the Practitioner to comply with any such special conditions.

6.9-4 Termination of Temporary Privileges

The CEO or designee may at any time, upon the recommendation of the

Chair of the Credentials Committee or the Chair of the Department concerned, terminate a Practitioner's temporary privileges effective as of the discharge from the Hospital of the patient(s) of that Practitioner then under his/her care in the Hospital. However, where it is determined that failure to terminate such temporary privileges may result in an imminent danger to the health of such patient(s), the termination shall be immediately effective and the Departmental Chair, or in his/her absence, the Chair of the Credentials Committee shall assign a member of the Medical Staff to assume responsibility for the care of such patient(s) until discharge from the Hospital. The wishes of the patient(s) shall be considered, where feasible, in the selection of such a substitute physician.

6.10 DISASTER PRIVILEGES

During disasters, the CEO may grant Disaster Privileges to volunteer licensed Practitioners. For purposes of this Section, a disaster is an emergency that, due to its complexity, scope, or duration, threatens the Hospital's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

6.10-1 Elements of Performance

(i) The Hospital shall grant Disaster Privileges to Practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the Hospital is unable to meet immediate patient needs;

(ii) The CEO, CMO, and Chief of Staff shall determine the specialties needed to meet the needs created by the disaster;

(iii) Volunteer Practitioners holding Disaster Privileges shall receive Hospital badges designating their status on the Medical Staff;

(iv) Volunteer Practitioners who are granted Disaster Privileges shall be monitored by direct observation and mentoring by the Chair of the appropriate Department, or their designees, as well as through medical record review.

(v) Before a Practitioner is considered eligible to function as a Volunteer Practitioner, the Hospital must obtain a copy of a valid government-issued photo identification for the Practitioner and at least one of the following:

- A current picture identification card from a healthcare organization that clearly identifies the Practitioner's professional designation;
- A current license to practice Practitioner's profession;
- Primary source verification of licensure;
- Identification indicating that the Practitioner is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or another recognized state or federal response organization or group;
- Identification indicating that the Practitioner has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances;

(vi) Confirmation in writing by a Practitioner currently privileged by the Hospital or by a Hospital employee with personal knowledge of the Practitioner's ability to act as a Volunteer Practitioner during the disaster.

(vii) During a disaster, the Medical Staff shall oversee the performance of each

Volunteer Practitioner.

(viii) Based on the Medical Staff oversight of a Volunteer Practitioner, the Hospital shall determine within seventy-two (72) hours of the Practitioner's receipt of Disaster Privileges whether or not the Disaster Privileges should continue.

(ix) Primary source verification of a Volunteer Practitioner's licensure shall be sought as soon as the disaster is under control, or within seventy-two (72) hours from the time the Volunteer Practitioner received Disaster Privileges, whichever comes first. If primary source verification of a Volunteer Practitioner's licensure cannot be completed within this time frame due to extraordinary circumstances, the Hospital must commence such verification as soon as possible and document each of the following:

(x) Reasons why verification could not be timely performed in accordance with this Section;

(xi) Evidence of the Practitioner's demonstrated ability to provide adequate care, treatment, and services to patients;

(xii) Evidence of all attempts to perform primary source verification.

(xiii) Primary source verification of licensure is not required if the Volunteer Practitioner has not provided care, treatment, or services under the Disaster Privileges.

6. 11 PROTECTION FROM LIABILITY

In all matters relating to granting, denying or otherwise delineating clinical privileges, all persons who participate shall be acting pursuant to and with the benefit of the same rights, privileges, immunities and authority as are provided in these Bylaws.

ARTICLE VII- CORRECTIVE ACTION

7.1 PROCEDURE FOR CORRECTIVE ACTION

7.1-1 Initiation of Corrective Action

Any officer of the Medical Staff, the Chair of any Clinical Department, the CEO or the Governing Body of the Hospital may request corrective action against any Practitioner whenever such Practitioner's activities or professional conduct are reasonably believed to be (a) lower than the standards or aims of the Medical Staff, (b) contrary to the Governing Body or the Medical Staff's Bylaws, Rules and Regulations, or (c) to be such that they adversely affect patient care in the Hospital. Instances in which the health or physical abilities of the Practitioner are at issue shall be initially handled in accordance with applicable Hospital policies and procedures, including but not limited to the Peer Review Processes set forth in Section 4.6 of these Bylaws.

7.1-2 Form of Request for Corrective Action

All requests for corrective action shall be in writing and shall be directed to and filed with the Credentials Committee of the Medical Staff. This request shall include the reason for such requested action.

7.1-3 Records; Pre-Credentials Committee Meetings

A complete and detailed written record or minutes of each formal interview or appearance before a committee which might be reviewed by the Credentials Committee in conjunction with corrective action, shall be made and shall include the name of the Practitioner, reasons for the meeting, pertinent information regarding the matter and the decisions or recommendations, whether favorable or adverse. The Practitioner shall, within thirty (30) calendar days, receive a copy of this record and this shall serve as official notification of any decisions or recommendations unless otherwise provided for in the Bylaws. A copy of each of these written records will be placed in the permanent file of the affected Practitioner by the Department Chair, or the Committee Chair, whichever is applicable. There is no right to a hearing or appeal with respect to these decisions or recommendations as they are preliminary in nature. Should the matter go forward to the Credentials Committee, the Practitioner can challenge the decision or recommendation at the Credentials Committee level and the Practitioner, if he/she properly requests a hearing before a Hearing Officer or Hearing Panel, can further challenge such decision or recommendation at such hearing.

7.1-4 Credentials Committee Powers

The action of the Credentials Committee upon a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, letter of reprimand, to impose terms of probation, or a requirement for consultation; to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension be terminated, modified or sustained, or to recommend that the Practitioner's Staff membership be suspended or revoked. Such action may include a recommendation to the Governing Body that a Practitioner's Medical Staff membership or clinical privileges be suspended as disciplinary or corrective action, for reasons less urgent than those warranting summary suspension, including but not limited to any of the following: the alleged violation of the Bylaws, Rules and Regulations of the Medical Staff, or Principles of Ethics adopted by the Medical Staff; charges of professional incompetency; conduct that is inimical to the Hospital, its staff, or the Medical Staff; conduct that either directly or indirectly adversely affects patient care in the Hospital.

7.1-5 Credentials Committee Procedures

Within thirty (30) days following the receipt of a request for corrective action, the Credentials Committee shall take action upon the request. Prior to taking such action the Credentials Committee shall afford the Practitioner an opportunity to appear before the Credentials Committee. Such appearance is preliminary in nature, does not constitute a hearing, and shall not be subject to procedural rules provided in these Bylaws for hearings. A record of such appearance or the failure of the Practitioner to accept the opportunity for such appearance shall be made.

7.1-6 Notice to the Chief Executive Officer

The Chair of the Credentials Committee shall promptly notify the CEO in writing of all requests for corrective action received by the Credentials Committee and shall continue to keep the CEO fully informed of all action taken in connection therewith.

7.1-7 Notice of Adverse Recommendation or Action

After the Credentials Committee has made its recommendation, the CEO shall promptly deliver to the Applicant or Practitioner (hereinafter the term "Practitioner" inclusively refers to both Applicant and Practitioner) special notice of any adverse recommendation or action in conjunction with an application for staff membership or clinical privileges or in conjunction with Peer Review activities or disciplinary actions or other professional review activities.

The recommendation by the Credentials Committee of corrective action as set forth in Section 8.1-2, whether or not a summary suspension is in effect, shall entitle the affected Practitioner to the procedural rights provided in Article VIII of these Bylaws.

All decisions and recommendations of the Credentials Committee shall be forwarded to the Governing Body for final action (except in the case of a recommendation of no action).

7.2 SUMMARY SUSPENSION

7.2-1 Initiation

The Chair of the Credentials Committee, Chief of Staff, Chair of a Clinical Department, or the CEO shall each have the right to summarily suspend a Practitioner's privileges for a period not to exceed fourteen (14) days during which an investigation is being conducted to determine the need for corrective action, if the person imposing the suspension reasonably believes that failure to take such action may result in an imminent danger to the health of any patient.⁵⁰ The suspension shall become effective immediately but shall not exceed fourteen (14) days unless following the Credentials Committee investigation during this period the Credentials Committee finds that termination of the summary suspension may result in imminent danger to the health of any patient.⁵¹

7.2-2 Credentials Committee Procedure⁵²

(a) Report. The person imposing a summary suspension shall immediately file a written report with the Credentials Committee, including a record of any interview with the

⁵⁰ MS 01.01.01 EP 30

⁵¹ MS 01.01.01 EP 29 and MS 01.01.01 EP 30

⁵² MS 01.01.01 EP 32 and EP 33

Practitioner whose privileges have been suspended, if an interview has been conducted. A copy of the report shall also be sent to the Practitioner.

(b) Credentials Committee Investigation. As soon as reasonably possible, not to exceed ten (10) calendar days following imposition of the summary suspension, the Credentials Committee shall convene to consider whether the summary suspension shall be terminated, modified or sustained. The Practitioner shall be notified of the date, time and place of Credentials Committee meeting at least twenty-four (24) hours in advance.

(c) Appearance before the Committee. The Credentials Committee shall afford the Practitioner subject to summary suspension an opportunity to appear before the Committee, inform the Practitioner of the general nature of the charges upon which the summary suspension was based, and invite the Practitioner to discuss, explain or refute them. Such appearance shall be preliminary in nature and shall not constitute a hearing, and shall not be subject to the procedural rules provided in these Bylaws for hearings. A record shall be made of the meeting and appearance or failure of the Practitioner to accept the opportunity to appear.

(d) Credentials Committee Decision. Within three (3) calendar days after its convening, the Credentials Committee must terminate the summary suspension unless it finds that such termination may result in an imminent danger to the health of any patient. Even if the Credentials Committee terminates the summary suspension, this shall not prohibit the Credentials Committee or other appropriate persons or committees from initiating corrective action with respect to the Practitioner dealing with the same issues.

7.2-3 Hearing

If within the fourteen (14) day suspension period the Credentials Committee does not terminate the summary suspension, the Practitioner shall be entitled to the procedural rights provided in these Bylaws in Article VIII. In all such cases, however, the summary suspension as sustained, or as modified by the Credentials Committee, shall remain in effect pending the final decision thereon of the Governing Body.

7.2-4 Alternate Medical Coverage

Immediately upon the imposition of a summary suspension, the Chair of the Credentials Committee or responsible Departmental Chair shall have the authority to provide for alternative medical coverage for the suspended Practitioner's patients remaining in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative Practitioner(s).

7.3 AUTOMATIC SUSPENSION

7.3-1 Action of the State Board of Medical Examiners

Action by the appropriate Professional State Board revoking or suspending a Practitioner's license shall result in automatic suspension of all Hospital privileges.⁵³

Action by the appropriate State Board placing the Practitioner on probation shall result in an automatic review of the Practitioner.⁵⁴ The CEO shall promptly advise the Practitioner in writing of such suspension or review.

Using the same time frame and procedures specified in Section 7.2-2 above, the Credentials Committee shall afford the Practitioner subject to automatic review because

⁵³ MS 01.01.01 EP 28 and EP 30

⁵⁴ MS 01.01.01 EP 30

of probation by the Board of Medicine an opportunity to appear before the Committee, shall inform the Practitioner of the general nature of the charges upon which the automatic review was based, and shall invite the Practitioner to discuss, explain or refute them. Such appearance is preliminary in nature and does not constitute a hearing, and is not subject to the procedural rules provided in these Bylaws for hearings. A record shall be made of the meeting and appearance or failure of the Practitioner to accept the opportunity to appear. If the Credentials Committee recommends immediate suspension of Hospital Privileges, the Practitioner shall be entitled to the procedural rights provided in Article VIII of these Bylaws.⁵⁵

7.3-2 Duty of the Chief of Staff

It shall be the duty of the Chief of Staff to cooperate with the CEO in enforcing all automatic suspensions.

7.4 PROTECTION FROM LIABILITY

In all matters relating to corrective action, including summary suspension or automatic suspension, all persons who participate shall be acting pursuant to and with the benefit of the same rights, privileges, immunities and authority as are provided for in Article V of these Bylaws.

⁵⁵ MS 01.01.01 EP 31 and EP 33

ARTICLE VIII - HEARINGS AND APPEALS

8.1 RIGHT TO HEARING AND APPELLATE REVIEW

8.1-1 General Provisions⁵⁶

A Practitioner holding an existing Medical Staff appointment shall be entitled to request a de novo formal hearing before a Hearing Panel whenever a recommendation unfavorable to Practitioner has been made by the Credentials Committee regarding those matters enumerated in Section 8.1-2 below. A Practitioner holding an existing Medical Staff appointment shall be entitled, upon proper request, to a de novo formal hearing before a Hearing Panel prior to the time the Governing Body enters a final decision, should the Governing Body preliminarily reject a favorable recommendation by the Credentials Committee regarding any of said matters. Any Practitioner shall be entitled, upon timely application, to appellate review by the Governing Body of any decision of the Hearing Panel (or Hearing Officer in the case of an initial application for Medical Staff membership and clinical privileges) which is adverse to the Applicant/Practitioner prior to the time final action is taken upon the matter by the Governing Body. No rights under this Article VIII attach to an individual seeking initial appointment to the Medical Staff unless that individual has been formally invited to apply for membership and has completed the requirements set forth in Section V to be considered an "Applicant".

8.1-2 Grounds for Hearing

No matter or action other than those hereinafter enumerated shall constitute grounds for a hearing and/or appeal or other review under these Bylaws:

- (i) Denial of an Applicant's initial Medical Staff appointment;
- (ii) Denial of requested change in Medical Staff category;
- (iii) Denial of Medical Staff reappointment;
- (iv) Revocation of Medical Staff appointment;
- (v) Denial of an Applicant's requested initial clinical privileges;
- (vi) Denial of requested increased clinical privileges;
- (vii) Revocation, decrease or restriction of clinical privileges;
- (viii) Suspension of Medical Staff privileges or clinical privileges.

8.1-3 Actions Without Hearing

Notwithstanding Section 8.1-2 above, neither automatic suspension of clinical privileges as provided for elsewhere in these Bylaws, nor the imposition of any consultation requirement, nor the imposition of a probationary period, nor the imposition of a requirement for retraining, additional training or continuing education, no matter whether imposed by the Credentials Committee or the Governing Body, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

8.2 NOTICE OF ACTION; REQUEST FOR HEARING

8.2-1 Notice of Action Warranting Hearing

In all cases in which a recommendation unfavorable to Practitioner has been made by the Credentials Committee regarding those matters enumerated in Section 8.1-2 above, the CEO shall give the Practitioner prompt notice of the recommendation and notice of the right to request

⁵⁶ MS 10.01.01 EP 1

a hearing pursuant to the provisions of this Article, in writing via Overnight Mail with confirmation of delivery. The notice shall:

(i) advise the Practitioner of the recommendation or action, briefly state the grounds upon which the adverse recommendation or action is based, and advise the Practitioner of his/her right to request a hearing pursuant to the provisions of the Medical Staff Bylaws;

(ii) specify that the Practitioner has thirty (30) days after receiving the notice within which to submit a written request for hearing and that within this thirty (30) day period the request must be served on the CEO by Certified Mail or Overnight Mail, with confirmation of delivery;

(iii) state that failure to request a hearing within the specified time period and in the proper manner as required under Section 8.2-2, or failure without good cause to appear in person as required by Section 8.3-3 shall be a waiver by the Practitioner which will automatically result in Practitioner losing all rights to any hearing or appellate review on the matter that is the subject of the notice;

(iv) enclose a copy of this Article VIII outlining the Practitioner's rights and the hearing procedures to be followed as provided for herein.

8.2-2 Request for Hearing

The Practitioner shall have thirty (30) calendar days following the date of the receipt of such notice under Section 8.2-1 above to file a written request for a hearing. The request must be delivered to the CEO by Certified Mail or Overnight Mail, with confirmation of delivery.

8.2-3 Waiver by Failure to Request a Hearing

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 8.2-2 above shall lose his/her right to any hearing or appellate review to which the Practitioner might otherwise have been entitled and the adverse recommendation or action shall be forwarded to the Governing Body and shall immediately become and remain effective against the Practitioner until such time as final action by the Governing Body.

8.3 NOTICE OF HEARING AND CHARGES; FAILURE TO ATTEND; RESCHEDULING HEARING

8.3-1 Notification of Hearing⁵⁷

Upon receipt of a proper request for hearing in compliance with Section 8.2-2 from a Practitioner entitled to the same, the CEO shall schedule and arrange for such hearing. The CEO shall notify the Practitioner of the time, place and date of the scheduled hearing by Certified Mail or Overnight Mail, with confirmation of delivery. Notice shall be deemed to have been given on the date it was delivered to the addressee. This hearing shall be held not less than fifteen (15) calendar days nor more than thirty (30) calendar days after the date of receipt of a proper request for hearing signed by the Practitioner.⁵⁸

8.3-2 Notice of Charges

The notice of hearing shall list all allegations and shall list all witnesses expected to give testimony or evidence on behalf of the Hospital. If the Practitioner is being charged with five (5) or fewer acts, omissions or incidents, then the notice of hearing shall state in concise language the acts, omissions or incidents with which the Practitioner is being charged. If the Practitioner is being charged with more than five (5) acts, omissions or incidents, then the notice of hearing need only state in concise language five (5) of the acts, omissions or incidents with which the Practitioner is being charged, but the notice must inform the Practitioner that these acts, omissions or incidents are representative of the types of acts, omissions or incidents for which the Practitioner is being questioned and that other acts, omissions or incidents of a similar or related nature may be dealt with at the hearing. In such a situation the Hearing Panel shall not be precluded from hearing evidence on any unlisted acts, omissions or incidents if they are of a nature similar or related to those specifically stated in the notice of hearing. If there are reasons for the Credentials Committee's adverse recommendation or decision other than specific acts, omissions or incidents involving the Practitioner, such reasons shall be stated in the notice of hearing in concise language.

8.3-3 Failure to Appear

No hearing shall be conducted without the personal presence of the Practitioner for whom the hearing has been scheduled unless the Practitioner waives such appearance or fails without good cause, as determined by the Hearing Panel, to appear for the hearing despite being given adequate notice. A Practitioner who fails to appear without good cause shall be deemed to have waived his/her rights to a hearing, to have voluntarily accepted the recommendation or decision, to have waived any right to appeal to the Governing Body and to have agreed that said recommendation or decision shall become and remain in effect until such time as acted on by the Governing Body.

8.3-4 Rescheduling of Hearings

Postponement or rescheduling of hearings beyond the time set forth in these Bylaws shall be made only with the approval of both the Hearing Panel and the Presiding Officer. Such postponements shall only be granted upon a showing of good cause by the Practitioner. If the Practitioner's request for a postponement has not been acted upon prior to the time scheduled

⁵⁷ MS 10.01.01 EP 2

⁵⁸ MS 01.01.01 EP 34

for hearing, the Practitioner must appear at the hearing, and if the Practitioner's request is at that time denied, then the hearing shall go forward. The fact that the Practitioner has requested a postponement shall not constitute justification or "good cause" for Practitioner's failure to appear at or to participate in the hearing.

8.4 HEARING PROCEDURE⁵⁹

8.4-1 Hearing Panel

When a hearing is requested, the Chief of Staff shall appoint a Hearing Panel which shall consist of four (4) persons, three (3) voting Members and an alternate. One (1) of the three (3) voting Members shall be designated as the Hearing Officer by the Chief of Staff. The alternate will not vote on or participate in post-hearing deliberations of the Hearing Panel unless one (1) or more Members of the Hearing Panel is not allowed to participate due to being absent during the presentation of testimony. The Hearing Officer shall preside over the deliberations of the Hearing Panel after the conclusion of the evidentiary hearing. Each Member of the Hearing Panel, including the alternate, shall be an MD or DO physician licensed to practice medicine in the State of Florida. Two (2) of such physicians must be past Chiefs of Staff of the Hospital Staff selected from among all available past Chiefs of Staff on a rotating basis. The third Member of the Hearing Panel shall be Board Certified or Board Eligible in the specialty practiced by the Practitioner. None of the Members of the Hearing Panel may be a direct economic competitor of the Practitioner, nor shall they have actively participated in the consideration of the matter involved at any previous level.⁶⁰

8.4-2 The Presiding Officer

The hearing shall be presided over by a Presiding Officer who is appointed by the Chief of Staff; who shall be a practicing attorney who is in good standing with The Florida Bar; who has civil trial experience; and who has not previously participated in formal deliberations, judicial or quasi-judicial proceedings involving the Practitioner. A panel of Presiding Officers, consisting of attorneys who meet the above specified criteria, and who have been approved by the Governing Body to act as Presiding Officers, shall be maintained by the CEO.

The Presiding Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Presiding Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. Any relevant matter upon which responsible persons might customarily rely in the conduct of serious affairs may be introduced, at the discretion of the Presiding Officer regardless of the admissibility of such evidence in a court of law. If the Presiding Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Presiding Officer may take such discretionary action as is warranted by the circumstances.

8.4-3 Witness Lists

If either side to the hearing makes a written request for a list of witnesses, then within ten (10) days after such request each party shall furnish to the other a written list of the names and addresses of the Practitioners, so far as is then reasonably known or anticipated, who may give

⁵⁹ MS 01.01.01 EP 34 and MS 10.01.01 EP 3 and EP 4

⁶⁰ MS 01.01.01 EP 35

testimony or evidence in support of the Practitioner at the hearing. Neither side in the hearing shall have any right to the discovery of documents or other evidence in advance of the hearing except for charts or other documents reviewed by the Credentials Committee in making its adverse recommendation. This shall not prohibit the parties from voluntarily exchanging copies of documents.

8.4-4 Procedural Disputes

It shall be the obligation of the Practitioner and the Credentials Committee, to notify the Presiding Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible so that decisions concerning such matters may be made in advance of the hearing. Objections to any such pre-hearing decisions may be briefly stated at the hearing.

8.4-5 Hearing Costs

As used herein, "hearing costs" shall consist of: (i) reasonable fees and costs paid to the Presiding Officer; (ii) reasonable fees and costs paid to the member of the Hearing Panel who is Board Certified or Board Eligible in the specialty practiced by the Practitioner if it is necessary to bring in a physician who is not a Member of the Medical Staff in order to assure that there is a physician of that specialty on the hearing panel who is not a direct economic competitor of the Practitioner. In every instance, such costs shall be initially advanced and incurred by the Governing Body but the Practitioner shall pay and reimburse the Governing Body an amount equal to one-half (1/2) of such costs within thirty (30) days of mailing by the Governing Body of interim and final invoices therefor to the Practitioner. The Practitioner and the Credentials Committee, in the event they are represented by counsel at the hearing, shall each be responsible for payment of their respective attorneys' fees and legal costs.

8.4-6 Rights of the Parties

Both the Practitioner and the Credentials Committee have the right to:

- (i) be represented at any phase of the hearing or pre-hearing procedures by an attorney at law or by any other person of that party's choice. Both sides shall notify the other of the identity of any such counsel at least ten (10) days prior to the hearing date;
- (ii) have a record of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;
- (iii) call, examine, cross-examine, and impeach witnesses, and the Credentials Committee shall have the right to call the Practitioner as if under cross-examination;
- (iv) to introduce documentary evidence determined by the Presiding Officer to be relevant and not redundant regardless of whether such evidence would be admissible in a court of law;
- (v) to submit a written statement at the close of the hearing.

8.4-7 Admissibility of Evidence

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Hearsay evidence shall not be excluded merely because it constitutes hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Panel may request such a

memorandum to be filed, following the close of the hearing. The Hearing Panel may interrogate the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate.

8.4-8 Record of Hearing

The Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Governing Body, but copies of the transcript shall be provided to the Practitioner upon request at his/her expense. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of Florida.

8.4-9 Burden of Proof

The Credentials Committee shall have the initial duty to present evidence in support of its action or recommendation. Thereafter the Practitioner has the burden of proving by a preponderance of the evidence that either (i) the adverse action or recommendation lacks substantial factual basis; or (ii) the adverse action or recommendation is unreasonable in light of the facts.

8.4-10 Adjournment and Conclusion

The Presiding Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and documentary evidence and the receipt of written statements submitted by the parties, the hearing shall be closed.

8.4-11 Deliberation, Recommendation and Report

At any time after the close of the evidentiary hearing and not later than five (5) days after the close of such hearing, the Hearing Panel under the direction of the Hearing Officer, shall reconvene in private to deliberate the issues and consider the evidence and, by majority vote to reach a recommendation to be forwarded to the Governing Body. The Presiding Officer shall not participate in the deliberations of the Hearing Panel. The recommendation of the Hearing Panel shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence, but shall not be based on evidence not introduced into evidence. Within thirty (30) calendar days after the final adjournment of the hearing, the Hearing Panel shall render a written recommendation which shall be accompanied by a report stating the reasons for the recommendation. The recommendation and report shall be delivered to the Credentials Committee, the Practitioner and the Governing Body through the CEO. Once the Hearing Panel has determined its recommendation, the Hearing Panel shall have the right to seek advice and assistance in the preparation of the written recommendation and report from the Presiding Officer or counsel of its choosing as long as such advice and assistance is not provided by an attorney representing the Credentials Committee or the Practitioner or any other attorneys in their firms respectively.

8.5 APPEAL TO THE GOVERNING BODY⁶¹

8.5-1 Time for Appeal

Within ten (10) days after notice of the Recommendation and Report of the Hearing Panel (or Hearing Officer if the Practitioner is a new Applicant) either party may request an appellate review by the Governing Body. The request shall be in writing, and shall be delivered to the CEO either in person or by Certified Mail, return receipt requested, and shall include a brief statement of the reasons for appeal. If such appellate review is not requested within ten (10) days as provided herein, both parties shall be deemed to have accepted the recommendation involved and it shall thereupon become final and immediately effective.

8.5-2 Grounds for Appeal

The grounds for appeal to the Governing Body from an adverse recommendation and report shall be that:

- (i) there was a substantial failure on the part of the Hearing Panel to comply with the Bylaws of the Medical Staff or the Hospital, which substantial failure resulted in the denial of due process or a fair hearing; or
- (ii) the recommendation of the Hearing Panel was made arbitrarily or capriciously or with prejudice; or
- (iii) the recommendation of the Hearing Panel is so unsupported by the record that no reasonable person could have made the same recommendation based solely on the record.

8.5-3 Time, Date Notice

Within five (5) business days after receipt of such notice of request for appellate review, the Chair of the Governing Body shall schedule a date for such review, and shall, through the CEO, by written notice sent by Certified Mail, return receipt requested, notify the affected Practitioner of the same. In the instance where the Certified Mail receipt is not returned by the addressee the notification will be forwarded by Overnight Mail. Notice shall be deemed to have been given on the date the notice was delivered to the addressee.

The date of the appellate review shall not be less than thirty (30) days, nor more than forty-five (45) days, from the date of receipt of the notice of request for appellate review, except that when the Practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not less than fifteen (15) nor more than twenty-five (25) days from the date or receipt of such notice.

8.5-4 Appellate Body

The appellate review shall be conducted by the Governing Body or by a duly appointed Appellate Review Committee of the Governing Body consisting of not less than four (4) members of the Governing Body.

8.5-5 Appeal Procedure

The appellate review shall be in the nature of an appellate hearing based upon the record of the proceedings before the Hearing Panel. The Appellate Body may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided

⁶¹ MS 10.01.01 EP 5

at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that any opportunity to admit it at the hearing was denied, and then only at the discretion of the Governing Body.

New or additional matters not raised during the hearing before the Hearing Panel (or Hearing Officer), nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances. The Governing Body or its Review Committee shall, in its sole discretion, determine whether such new matters shall be introduced. The Practitioner may, at any time prior to five (5) days before the meeting of the Governing Body at which the Practitioner's appellate review will be considered, submit to the Governing Body a brief written statement of the "unusual circumstances" which, in the Practitioner's opinion, would allow the raising of new or additional matters which the Practitioner wishes to raise. Nothing herein shall preclude the Governing Body from seeking legal advice from its attorney regarding the interpretation of "unusual circumstances" as contemplated in this section. Neither the Practitioner nor the Credentials Committee nor any of their representatives shall have the right to address the Governing Body with respect to the appellate review for a time period in excess of five (5) minutes to address the "unusual circumstances" only.

8.5-6 Submission of Written Statements

Each party shall have the right to present a written statement in support of its position on appeal, and in its sole discretion, the Governing Body may allow each party or its representative to appear personally and make oral argument. Each party shall submit its written statement no later than five (5) business days prior to the date scheduled for appellate review. Written statements shall be submitted to the Governing Body through the CEO by Certified Mail, return receipt requested, and shall simultaneously be served by Certified Mail, return receipt request, to the other party. No written statement shall exceed twenty (20) pages, including exhibits. At its discretion the Governing Body may choose not to consider any improperly filed or served written statement, and any portion of a written statement in excess of twenty (20) pages may be ignored by the Governing Body.

Within thirty (30) days after the conclusion of the appellate review proceeding, the Governing Body shall render a final decision in writing and shall deliver copies thereof to the Practitioner and the Chair of the Credentials Committee, in person or by Certified Mail, return receipt requested. In the instance where the Certified Mail receipt is not returned by the addressee the notification will be forwarded by Overnight Mail.

The Governing Body may affirm, modify or reverse the recommendation of the Hearing Panel or, in its discretion, refer the matter for further review and recommendation.

Except where the matter is referred for further action and recommendation, the final decision of the Governing Body following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Governing Body in accordance with the instructions given by the Governing Body. This further process and the report back to the Governing Body shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.

8.5-7 Miscellaneous

Neither Practitioner nor the Credentials Committee nor their respective representatives shall lobby, coerce or otherwise communicate with members of the Governing Body regarding an upcoming appellate review except as specifically authorized hereinabove. Any violations of this

provision are to be reported at the appellate review and taken into consideration by the Governing Body. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in Section 8.5 have been completed or waived.

8.6 HEARING FOR NEW APPLICANT (Hearings authorized by Section 8.1-2(i))

8.6-1 Pre-Hearing Procedure

In all cases in which the Credentials Committee has made a recommendation which is unfavorable to a new Applicant regarding the matters enumerated in Section 8.1- 2, or to a Practitioner who applied for a change in Medical Staff category or additional/increased clinical privileges but was denied based upon the Practitioner's failure to meet existing threshold criteria, the Applicant shall have a period of thirty (30) calendar days after the mailing of the adverse decision or recommendation and notice of the right to hearing, in which to request a hearing. If the Applicant requests a hearing, the CEO shall appoint a Hearing Officer, who shall be a former Chief of Staff who has not been involved in any aspect of the recommendation being appealed, and schedule and arrange for such a hearing. The Hearing Officer shall, through the Hospital's CEO, notify the Credentials Committee and the Applicant by Certified Mail, return receipt requested, of the time, place and date of the hearing and of the basis for the adverse recommendation by the Credentials Committee, shall list the witnesses expected to testify at the hearing, shall advise the Applicant of the right to be represented by counsel and of the right to call as witnesses those persons whose names he/she provides to the CEO not less than ten (10) calendar days before the hearing. The hearing date shall be not be less than twenty (20) calendar days from the date of the receipt of the request for hearing. In the instance where the Certified Mail receipt is not returned by the addressee the notification will be forwarded by Overnight Mail. Notice shall be deemed to have been given on the date the notice was delivered to the addressee.

8.6-2 Rescheduling of Hearing

The Applicant shall be entitled to request only one change in the scheduled hearing time. Granting such change in the hearing time shall be only for good cause shown and shall be at the sole discretion of the Hearing Officer. If the Applicant's request for a change in the hearing date has not been granted prior to the time scheduled for the hearing, the Applicant must appear at the hearing, and if the Applicant's request is denied, then the hearing shall go forward. The fact that the Applicant has requested that the hearing be rescheduled shall not constitute a justification or "good cause" for Applicant's failure to appear at the hearing, and if the Applicant fails to appear under such circumstances, the Applicant shall be deemed to have waived his/her rights to a hearing and the adverse recommendation shall become and remain in effect until final action by the Governing Body.

8.6-3 Hearing Procedure

The hearing shall be conducted before a Presiding Officer appointed by the CEO from a panel of Presiding Officers established pursuant to Section 8.4-2 above. Only the Presiding Officer and Hearing Officer, the Applicant, a representative of the Credentials Committee and counsel for the parties may be present at the hearing. The Applicant shall have a reasonable opportunity to present relevant oral and documentary evidence at the hearing. An accurate recording or transcription of the proceedings will be kept as set forth in Section 8.4-8.

8.6-4 Conclusion of Hearing

Within ten (10) calendar days after the conclusion of the hearing, the Hearing

Officer will submit a written recommendation and a supporting written report to the Credentials Committee and the Governing Body through the CEO. The CEO shall promptly send a copy of the recommendation and report to the Applicant and if the recommendation is adverse, then it shall be sent by Certified Mail and must be accompanied by a Notice of Right to Appeal as provided in Section 8.5. In the instance where the Certified Mail receipt is not returned by the addressee the notification will be forwarded by Overnight Mail.

8.6-5 General Provisions

The appeal to the Governing Body shall be conducted according to the procedures in Section 8.5 above.

8.7 FINAL APPELLATE REVIEW DECISION BY GOVERNING BODY

8.7-1 Decision

Within twenty (20) calendar days after the conclusion of the appellate review, the Governing Body shall make its decision in the matter and shall send written notice thereof through the CEO to the Credentials Committee by hand delivery, and to the Practitioner, by Certified Mail, return receipt requested. In the instance where the Certified Mail receipt is not returned by the addressee the notification will be forwarded by Overnight Mail. Notice shall be deemed to have been given on the date the notice was delivered to the addressee. The decision by the Governing Body shall be immediately effective and final and shall not be subject to further hearing or appellate review unless the Governing Body refers the matter back to the Hearing Panel with instructions for further action, including, at the sole discretion of the Governing Body, a directive that an "additional hearing" not to exceed one (1) day be held to clarify facts still in doubt. The Hearing Panel shall comply with the Governing Body's instructions and within two (2) weeks, forward the additional record and updated recommendation and report to the Governing Body. The Governing Body shall then make its final decision with like effect and notice as first above provided in Section 8.5-6.

8.7-2 Right to One Hearing

Notwithstanding any other provision of these Bylaws, no Practitioner shall have more than one (1) hearing, one (1) "additional hearing" and one (1) appellate review on any matter which has been the subject of a recommendation and report by the Hearing Panel.

8.8 PROTECTION FROM LIABILITY

In matters relating to hearings and appellate reviews, all persons who participate shall be acting pursuant to and with the benefit of the same rights, privileges, immunities and authority as are provided for in these Bylaws.

ARTICLE IX - OFFICERS

9.1 OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be Chief of Staff, Chief-Elect, and Secretary/Treasurer.⁶²

9.2 QUALIFICATIONS OF OFFICERS

Officers must be members of the Active or Senior Active Medical Staff at the time of nomination and election and must remain Members in good standing during their term of office.⁶³ Failure to maintain such status shall immediately create a vacancy in the office involved.

9.3 ELECTION OF OFFICERS⁶⁴

(a) The office of Secretary/Treasurer shall be elected at the Annual Meeting of the Medical Staff. At least eight (8) weeks prior to the date of the Annual Meeting, a notice shall be sent to all Active and Senior Active Members (the Voting Members), calling for those interested in serving in Medical Staff leadership to submit their names to the Medical Staff Office or the Chief of Staff no later than four (4) weeks prior to the Annual Meeting. The Nominating Committee may also submit names for the office of Secretary/Treasurer.

(b) All candidates interested in serving as Secretary/Treasurer shall meet with the Nominating Committee and/or the CMO or the CMO's designee prior to the preparation of the ballot in order to understand the duties and responsibilities of the Medical Staff Officers. Failure to have such a meeting will result in the Member's name not being placed on the ballot.

(c) The Nominating Committee shall prepare a ballot listing in alphabetical order the names and practice specialty of all candidates for the office of Secretary/Treasurer. The ballot must be sent to all Voting Members of the Medical Staff no later than ten (10) days prior to the Annual Meeting.

(d) Initial ballots shall be cast at the time the Voting Member signs in at the Annual Meeting. If a Voting Member does not have the original ballot at the time of sign-in, an official facsimile ballot shall be provided. The CMO may take all reasonable steps to ensure a valid election process. Each ballot cast must select only one (1) candidate for Secretary/Treasurer.

(e) Election shall be by a majority of Voting Members present. There shall be no proxy votes. In the event no candidate receives a majority of votes cast, the name of the candidate with the least number of votes shall be removed from consideration and a new vote taken. This procedure shall be repeated until one (1) candidate receives a majority vote. In the case of a tie, the outgoing Chief of Staff shall cast the deciding vote.

9.4 TERM OF OFFICE

All officers shall serve a two (2) year term with the option to continue on in the same capacity for one (1) additional one (1) year term. Officers shall take office on the first day of the Medical Staff year. On that date, each incumbent officer shall automatically assume the next senior office, with the Secretary/Treasurer position being filled in accordance with Section 9.3.

⁶² MS 01.01.01 EP 19

⁶³ 42 CFR §482.22(b)(3)

⁶⁴ MS 01.01.01 EP 18

9.5 VACANCIES IN OFFICE

9.5-1 Vacancy

Vacancies may occur upon the death, disability, resignation, or removal from office or upon failure to maintain active staff in good standing. Any officer of the Medical Staff may resign at any time by giving written notice to the Executive Committee. The acceptance of such resignation is not required to become effective. Vacancies in office during the Medical Staff year shall be filled by the immediately following officer moving into the vacant position, and all other officers moving up similarly to the next senior office. In case of a vacancy in the Secretary/Treasurer position, the Executive Committee of the Medical Staff shall appoint a member of the Active or Senior Medical Staff to fill the position for the remainder of the term.

9.5-2 Removal

Removal of an officer of the Medical Staff may be initiated by a two-thirds (2/3) vote of the Members of the Executive Committee.⁶⁵ No such removal shall be effective unless and until it is ratified by a two-thirds (2/3) vote of the Active Members, at a meeting that shall be held no longer than thirty (30) days following the action of the Executive Committee. Failure to perform duties listed in Section 9.6 constitutes condition for removal from office.

9.6 DUTIES OF OFFICERS

9.6-1 Chief of Staff

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff and:⁶⁶

- (i) act in coordination and cooperation with the CEO in all matters of mutual concern within the Hospital;
- (ii) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
- (iii) serve as Executive Committee Chair;
- (iv) serve as advisory member of all other Medical Staff Committees without vote;
- (v) be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staffs compliance with the procedural safeguards in all instances where corrective action has been requested against a Practitioner;
- (vi) appoint Committee Members to all standing, special and multi-disciplinary Medical Staff Committees with Executive Committee ratification, and consistent with the Bylaws (Article XI).
- (vii) represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the CEO.
- (viii) receive and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with

⁶⁵ MS 01.01.01 EP 18

⁶⁶ 42 CFR §482.22(b)(3)

respect to the Medical Staff's delegated responsibility to provide medical care;

(ix) be the spokesman for the Medical Staff in its external professional and public relations; and

(x) keep the entire Medical Staff informed concerning the accreditation program, the current accreditation status of the Hospital, and the factors influencing that status.

9.6-2 Chief-Elect

In the absence of the Chief of Staff, the Chief-Elect shall assume all the duties and have the authority of the Chief of Staff. He/she shall be a member of the Executive Committee of the Medical Staff. He/she shall automatically succeed the Chief of Staff when the latter fails to serve for any reason. In the event of the permanent assumption of the duties of the Chief of Staff by the Chief-Elect, in the event of the Chief of Staff being unable to serve the full term for any reason, a new election for Chief-Elect shall be held as soon as practical to fill the position of Chief-Elect for the remainder of the unexpired Medical Staff year. This nomination and election shall be held in the usual specified manner as stated in these Bylaws for other Staff officers.

9.6-3 Secretary/Treasurer

The Secretary/Treasurer shall be a member of the Executive Committee of the Medical Staff. The Secretary/Treasurer shall be responsible for accurate and complete minutes of all Medical Staff meetings, and shall call Medical Staff meetings on order of the Chief of Staff; attend to all correspondence; and perform such other duties as ordinarily pertain to his/her office.

ARTICLE X- CLINICAL DEPARTMENTS

10.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND SERVICES

Each Department and service shall be organized as a separate part of the Medical Staff and shall have a Chair who shall be responsible to the Executive Committee and Medical Staff.⁶⁷ Each Department shall determine in its Rules and Regulations the separation of subsections within the Department appropriate to organizing and performing the work of the Department. Each Hospital Professional Service must have Rules and Regulations approved by the Executive Committee delineating provisions for election of officers, membership, regular meeting and describing areas of responsibility.

10.1-1 Clinical Departments

- (i) Department of Anesthesiology
- (ii) Department of Emergency Services
- (iii) Department of Medicine
- (iv) Department of Obstetrics and Gynecology
- (v) Department of Oncology
- (vi) Department of Pathology
- (vii) Department of Pediatrics
- (viii) Department of Psychiatry
- (ix) Department of Radiology
- (x) Department of Surgery

10.1-2 Hospital Professional Services

- (i) EEG
- (ii) EKG
- (iii) EMG
- (iv) Rehabilitative Services
- (v) Respiratory Therapy

10.2 QUALIFICATIONS, SELECTION AND TENURE OF DEPARTMENT CHAIRS

10.2-1 Election/Qualification⁶⁸

Each Chair shall be a Member of the Active Staff who possesses the qualifications set forth in Article IV herein. Such Practitioner must also be Board Certified by the appropriate specialty Board, or be Board Eligible unless waived by the Governing Body. The Chair of a Department is elected at intervals as shall be specified in the Rules and Regulations of that Department and by a majority vote of the Members present at the meeting for election. Failure to maintain membership in good standing on the Active Medical Staff shall immediately create a vacancy in the office involved.

⁶⁷ 42 CFR §482.22(c)(3) and MS 01.01.01 EP 12

⁶⁸ MS 01.01.01 EP 36

10.2-2 Removal

Removal of a Chair during his/her term of office may be initiated by a two-thirds (2/3) majority vote of all Active Staff members of the Department but no such removal shall be effective unless and until it has been ratified by the Executive Committee. The Executive Committee may initiate the removal of a Department Chair during his/her term of office by a two-thirds (2/3) vote, and instruct the Department to elect a new Chair.

10.2-3 Vacancy

In the event a Department Chair dies, resigns or is removed from office, then the Chief of Staff shall assign another Member of the Department who satisfies the qualifications set forth in Section 10.2-1 herein and who is approved by the Executive Committee to assume the duties of the Department Chair until such time as a special election is held to elect a new Department Chair.

10.3 RESPONSIBILITIES OF DEPARTMENT CHAIRS

Each Chair shall:⁶⁹

(i) be accountable for all clinical and administrative activities within his/her service and OPPE/FPPE/Peer Review;

(ii) give guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his/her own Department in order to assure quality patient care, and the integration of the Department into the primary functions of the Medical Staff;

(iii) maintain surveillance of the professional performance of all Practitioners with clinical privileges in his/her Department and report regularly thereon to Credentials Committee;

(iv) be responsible for compliance with the Hospital Bylaws and of the Medical Staff Bylaws, Rules and Regulations within his/her Department;

(v) be responsible for implementation within his/her Department of actions taken by the Executive Committee of the Medical Staff;

(vi) recommend to the Credentials Committee the criteria for clinical privileges that are relevant to the care provided in the Department;

(vii) Maintain continuing review of the professional performance of all Practitioners with clinical privileges in the Department (including but not limited to participation in FPPE and OPPE in compliance with applicable Medical Staff policies, with information and/or support provided by the Hospital Quality Department and Credential Services; and to recommend clinical privileges for each Member of the Department to the Credentials Committee when the Chair of the Department is satisfied there are no outstanding FPPE or OPPE issues for any Practitioner for appointment or reappointment to the Medical Staff;

(viii) be responsible for the teaching, education and research program in his/her Department;

(ix) participate in every phase of administration of his/her Department through cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, space, supplies, special regulations, standing orders and techniques. This shall include recommendations for a sufficient number of qualified and competent persons to

⁶⁹ MS 01.01.01 EP 36

provide care of service;

(x) as part of the credentialing process participate in the assessment of the qualifications and competence of Department or service personnel who are not LIP and who provide patient care, treatment, and services;

(xi) review all discrepancies referred to him/her by Governing Body, Hospital, or Medical Staff committee and make dispositions on the recommendations of such committee;

(xii) continuously monitor and evaluate quality and appropriateness of care and monitor quality control programs, as appropriate;

(xiii) assess and recommend to Hospital Administration off-site sources for needed patient care services not provided by the Department or Hospital; and

(xiv) perform an annual assessment of the number of Department Members who are approaching eligibility for Senior Staff status, to determine the adequacy of Service Call coverage within the Department.

ARTICLE XI -COMMITTEES

11.1 MEDICAL EXECUTIVE COMMITTEE⁷⁰

11.1-1 Composition⁷¹

The Medical Executive Committee shall consist of the Chief of Staff who acts as Chair, the Chief-Elect, Immediate Past Chief, , the Secretary/Treasurer, the Chair of Medicine, the Chair of Surgery, the Chair of Obstetrics/Gynecology, the Chair of Pediatrics, one (1) elected representative for the employed physicians to include Oncology, Emergency Medicine, Hospitalists, Psychiatry, Family Medicine, and Medical Intensivists and one (1) elected representative of the exclusively contracted physician groups to include Anesthesia, Pathology and Radiology. All Members are voting Members unless otherwise designated. No Member of the Active Medical Staff shall be ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline or specialty.⁷² Members may attend meetings telephonically. Members of the Medical Executive Committee shall carry out their duties without regard to any personal or financial conflicts of interest, and shall recuse themselves in good faith from any discussion, consideration, vote, or action regarding an Applicant for Medical Staff Membership or a Member, or other medical staff action, where a conflict of interest may be perceived or exist.

11.1-2 Duties⁷³

The duties of the Medical Executive Committee (also referred to as the “Executive Committee”) shall be:

- (i) to represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws, and without regard to any personal or financial conflicts of interest;
- (ii) to coordinate the activities and general policies of the various Departments;
- (iii) to receive and act upon Committee reports, and to make comments or recommendations concerning them to the CEO, the CMO, and the Governing Body;
- (iv) to implement policies of the Medical Staff not otherwise the responsibility of the Departments;
- (v) to provide liaison between Medical Staff and the CEO and the Governing Body;
- (vi) to recommend action to the CEO on matters of a medico-administrative nature;
- (vii) to make Medical Staff membership recommendations to the Governing Body for its approval through the Chief of Staff. This duty may be performed by the Credentials Committee, acting on behalf of the Medical Executive Committee;
- (viii) to fulfill the Medical Staff’s accountability to the Governing Body for the medical care rendered;
- (ix) to ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;
- (x) to provide for the preparation of all meeting programs, either directly or through delegation to a Program Committee or other suitable agent;
- (xi) to take all reasonable steps to ensure professionally ethical conduct and

⁷⁰ MS 02.01.01

⁷¹ MS 01.01.01 EP 20

⁷² 42 CFR §482.22(b)(2) and MS 01.01.01 EP 21 and EP 22

⁷³ MS 01.01.01 EP 20 and EP 23

competent clinical performance on the part of all Members, including the initiation of Medical Staff corrective or review measures when warranted;

(xii) to report at each General Staff meeting;

(xiii) to recommend the yearly dues;

(xiv) to investigate any breach of ethics that is reported to it;

(xv) to act for the Medical Staff in the intervals between Medical Staff meetings;

(xvi) to make recommendations to the Governing Body concerning: Medical Staff structure; mechanisms used to review credentials and delineate privileges, including termination of Medical Staff membership and fair hearing procedures; participation and organization of Medical Staff performance improvement activities; and establishment of mechanisms to conduct, evaluate, and revise performance improvement activities.

(xvii) to ensure participation of the Medical Staff in performance improvement activities.

11.1-3 Actions

Actions of the Medical Executive Committee shall become effective at the time of their adoption, subject to amendment or appeal by the Governing Body.

11.1-4 Regular Meetings

The Medical Executive Committee shall meet at least quarterly and maintain a permanent record of its proceedings and actions. Fifty (50) percent of the voting Members shall constitute a quorum, and a majority vote of all voting Members present is required for action or to pass a motion.

11.1-5 Special Meetings

A special meeting of the Medical Executive Committee shall only be called by the Chief of Staff at his/her discretion, at the written request of the Governing Body, the CEO, or at the request of three (3) of the voting Members of the Medical Executive Committee. Notice of the special meeting shall be made within fourteen (14) days of receipt of the request, with the meeting being held not less than seven (7) days nor more than twenty-one (21) days thereafter. A written agenda will be prepared and distributed by the Chief of Staff at the same time as the notification of time and place of the meeting. No discussion or action may be taken on subjects not on the written agenda at such Special Meeting. In the event that an issue requires Medical Executive Committee action but there is insufficient time to wait for a special Medical Executive Committee meeting, the Medical Executive Committee may be presented with the question(s) by mail or email and their votes returned to the Chief of Staff by mail or email within the time period specified. Such a vote shall be valid so long as the question(s) are voted on by a majority of the Medical Executive Committee eligible to vote.

11.1-6 Removal of Members

Members of the Medical Executive Committee may be removed by a two-thirds (2/3) vote of the Medical Executive Committee. This action must be considered at the next meeting of the General Medical Staff.⁷⁴

⁷⁴ MS 01.01.01 EP 21

11.1-7 Conflict Management⁷⁵

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least fifty (50) percent of the voting Members) regarding a proposed or adopted rule or policy, or other issue of significance to the Medical Staff, the Chief of Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of up to five (5) Members of the voting General Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee and the petitioners' representatives shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the General Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioners' representatives. Unresolved differences shall be submitted to the Governing Body for its consideration in making its final decision with respect to the proposed rule, policy, or issue.

11.2 CREDENTIALS COMMITTEE

11.2-1 Composition

The Credentials Committee shall consist of the current Chief of Staff, the Immediate Past Chief of Staff, Chief-Elect, CMO, and Chair of each of the following Departments: Medicine, Obstetrics and Gynecology, and Surgery. The Credentials Committee Chair shall be the Immediate Past Chief of Staff. If no Member has served longest, then the Member who served as Chief of Staff earliest shall be Chair.

The current CEO, COO, and General Counsel shall be an ex-officio, non-voting member of the Committee, and shall not count towards establishing a quorum. The Chairs of the following Departments may be invited to attend as non-voting Members when appropriate for input on Practitioner(s) who might be credentialed in their respective Departments: Anesthesiology, Emergency Medicine, Pathology, Radiology, and a representative for the Non-Physician Providers. Members may attend meetings telephonically. Members of the Credentials Committee shall carry out their duties without regard to any personal or practice-related conflicts of interest, and shall recuse themselves in good faith from any discussion, consideration, vote or action regarding an applicant for Medical Staff Membership or a Member, or any Medical Staff action, where a conflict of interest may be perceived or exist.

11.2-2 Duties

The duties of the Credentials Committee shall be:

- (i) to review the credentials of all Applicants and make recommendations for Membership and delineation of clinical privileges on behalf of the Executive Committee and to otherwise perform all of the duties and obligations imposed by and in compliance with Articles V, VI, VII and VIII of these Bylaws, without regard to any personal or financial conflicts of interest;
- (ii) to review periodically all information available regarding the competence of Staff Members or Applicants for Membership, including but not limited to the Staff Members'

⁷⁵ MS 01.01.01 EP 10

activities at other healthcare facilities, and as a result of such review, to make recommendations on behalf of the Executive Committee for the granting of privileges, reappointment, and the assignment of Practitioners and the various Departments or services as provided in Article V and Article VI of these Bylaws;

(iii) to review reports that are referred by the Medical Executive, Medical Record, Department Chair, Peer Review, and Utilization Review Committees and by the Chief of Staff. Additionally, to request and review reports of any corrective action or informal conduct/behavior issues, and any ongoing FPPE/OPPE issues regarding a Practitioner seeking reappointment to the Medical Staff from the Department Chair and Hospital Quality Department (or any other Department with relevant information) prior to making a recommendation for reappointment;

(iv) to review the credentials of all Applicants who request to practice at the Hospital as NPP, and to make a report of its findings and recommendations on behalf of the Credentials Committee, in accordance with Article III herein;

(v) in the event of special circumstances, the Credentials Committee may request the Governing Body to hold a special meeting to consider privileging issues in the event that prompt action by the Governing Body is required;

(vi) to review and resolve any possible conflicts of interest in the Peer Review process that are brought to the Credentials Committee by the affected Practitioner, and if unable to resolve the issue, to refer the matter to an ad hoc committee appointed in the same manner as the Hearing Panel set forth in Section 8.4-1.

11.2-3 Meetings

The Credentials Committee shall meet regularly throughout the year in order to accomplish its responsibilities as set forth by these Bylaws, at least ten (10) times per year, or more often as deemed necessary; shall maintain a permanent record of its proceedings and actions; and shall report its recommendations to the Medical Executive Committee through the Chief of Staff, to the CEO and to the Governing Body. Fifty (50) percent of the voting Members shall constitute a quorum, and a majority vote of all voting Members present is required for action or to pass a motion.

11.3 BYLAWS COMMITTEE

11.3-1 Composition

The Chairperson and Members shall be appointed by the Chief of Staff from Members of the Active Staff for a period of one (1) fiscal year.

11.3-2 Meetings

Meetings shall be held as deemed necessary by the Chief of Staff or the Chair of the Committee in accordance with such matters as require consideration.

11.3-3 Duties

The Committee shall be responsible for the consideration of any proposed changes or amendments to or revision of, the Bylaws of the Medical Staff, for formulating nomenclature or working of each Bylaw change, reconciling them with current Bylaws and submitting them to the Committee after review. The standard procedure for adoption or rejection of such changes shall proceed in accordance with Article XV.

The Committee shall review the Bylaws at least every two (2) years.

11.4 OTHER STANDING AND SPECIAL COMMITTEES

Any other Standing Committee, Special Committee, and their Chairs shall be appointed by the Chief of Staff from the Members of the Active Staff or Senior Active Staff in accordance with the Medical Staff Rules and Regulations. The Chairs of these committees must be a Member of the Active Staff, with full privileges. When such committees are appointed, they must be charged specifically and in writing with their duties and responsibilities.

11.5 MEETINGS OF ALL COMMITTEES

Meetings of all committees shall be open to any Member of the Medical Staff; however, such guests may not enter into discussions of the committee except by permission of the Chair.

Upon initiation of a motion by one of the Members of a committee and a majority vote, any committee shall have the privilege of going into "Executive Session".

In the event a Member of any committee has a direct personal or financial interest in any action being considered by the committee, that Member shall recuse himself/herself from the vote and any discussion following a duly stated motion. However, nothing herein shall prohibit such Member from providing information to the committee of which he/she has personal knowledge.

ARTICLE XII- MEDICAL STAFF MEETINGS

12.1 ANNUAL MEETING

The annual meeting of the Medical Staff shall be held prior to the end of the fiscal year of the Hospital. At this meeting the retiring officers and committees of the Medical Staff shall make reports as may be requested by the Chief of Staff or required by these Bylaws. All officers and all elected committee Members of the ensuing year shall be elected. The Medical Staff may also take any action required of it, by presenting issues for discussion and vote in person at the annual meeting. Twenty-five (25) percent of the voting Medical Staff Members shall constitute a quorum, and a majority vote of all Members present is required for action or to pass a motion.

12.2 REGULAR MEETINGS

There may be three (3) regular meetings of the Medical Staff in addition to the Annual Meeting in September during each fiscal year of the Hospital, on a date and time designated by the Chief of Staff for the purpose of reviewing and evaluating Department and committee reports and recommendations, and acting on any other matters placed on the agenda by the Chief of Staff.

12.3 SPECIAL MEETINGS

A special meeting of the Medical Staff shall only be called by the Chief of Staff:

- (i) at his/her discretion;
- (ii) at the written request of the Governing Body;
- (iii) by order of the Executive Committee; or
- (iv) at the request of fifteen (15) percent of the voting Members of the Medical

Staff.

Notice of the special meeting shall be made within fourteen (14) days of receipt of the request with the meeting called not less than seven (7) days, nor more than twenty-one (21) days, thereafter. (If mandatory attendance is required, notification of the meeting must be made at least thirty (30) days prior to the meeting date to all Members whose attendance is required.) A written agenda will be determined and distributed by the Chief of Staff at the same time as the notification of time and place of the meeting. No discussion or action may be taken on subjects not on the written agenda. In the event that an issue requires Medical Staff action, but there is insufficient time to wait for a special Medical Staff meeting, the Medical Staff may be presented with the question by mail and their votes returned to the Chief of Staff by mail. Such a vote shall be valid so long as the question is voted on by a majority of the Medical Staff eligible to vote.

12.4 QUORUM

Unless otherwise specified for specific Medical Staff Committees in these Bylaws, the presence of twenty-five (25) percent of the total membership of the voting Members of Medical Staff at any regular or special meeting or other Medical Staff meeting shall constitute a quorum, and Members or guests at such meetings may appear telephonically. Once a quorum is established at any committee meeting or other medical staff meeting, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

12.5 STURGIS STANDARD CODE OF PARLIAMENTARY PROCEDURE

Unless otherwise specified, meetings shall be conducted according to Sturgis Standard Code of Parliamentary Procedure.

12.6 ATTENDANCE REQUIREMENTS

12.6-1 Medical Staff Meetings

Each Active, Associate and Senior Staff Member is encouraged to attend all regular Medical Staff meetings and applicable Department and committee meetings in each year. Attendance is required at least two (2) Medical Staff meeting per year. Attendance shall be enforced according to the policy "Attendance at Medical Staff Meetings" policy.

12.6-2 Department Meetings

All Active or Associate Staff Members are encouraged to attend a minimum of two (2) meetings per year of the Department to which he/she is assigned. A Clinical Department may require in its Rules and Regulations a category or categories of Members, or all Members, to attend a specific number or percentage of meetings.

12.7 AGENDA

The agenda at any regular Medical Staff meeting shall be prepared by the Chief of Staff.

The agenda at special meetings shall be:

- (i) call the meeting to order;
- (ii) transaction of business for which the meeting was called;
- (iii) adjournment.

ARTICLE XIII- MEDICAL STAFF DUES AND FEES

13.1 DUES

Except as otherwise provided in these Bylaws, all persons appointed to the Medical Staff shall pay biennial staff dues to the Hospital's Medical Staff fund as may be required by the Executive Committee.

13.2 FEES

An application fee shall accompany all applications for Staff membership and reappointment, as recommended by the Credentials Committee as approved by the Medical Executive Committee. Additional fees may be imposed for non-attendance of the required Medical Staff meetings per Article 12.6 and as outlined in the policy "Attendance at Medical Staff Meetings" policy.

ARTICLE XIV- RULES AND REGULATIONS

14.1 GENERAL

Medical Staff Rules and Regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws, or to ensure compliance with applicable laws, regulations, accreditations or certifications, shall be adopted in accordance with this Article. Rules and Regulations shall set standards of practice which are to be required of each Practitioner exercising clinical privileges in the Hospital, and shall act as an aid in evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as the Bylaws.

14.2 ADOPTION AND AMENDMENT

Rules and Regulations may be adopted, amended, repealed, or added as recommended by the Bylaws Committee or the Credentials Committee in a meeting of the Executive Committee at any regular or special meeting, and become effective on the date(s) specified in such Rule or Regulation, or upon the date of approval by the Executive Committee.

14.3 URGENT ACTION⁷⁶

How the Medical Staff shall act when urgent action is required to comply with law or regulation shall be set forth in the Medical Staff Rules and Regulations.

⁷⁶ MS 01.01.01 EP 11

ARTICLE XV- AMENDMENTS AND REVISIONS

15.1 REQUEST BY MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee shall request the Bylaws Committee to review and revise the Medical Staff Bylaws in part or in their entirety, upon receipt of a request for revision as provided herein, or upon its own action. The Governing Body, CEO, or any Member of the Active Staff may request consideration of an amendment or revision by filing such a request in writing with the Chair of the Bylaws Committee, Chief of Staff, or Chair of the Medical Executive Committee. Following study of the proposed change by the Bylaws Committee, the Chair shall submit its recommendation in writing to the Medical Executive Committee for their review. Upon approval of the Medical Executive Committee, the black-lined amendment or revision shall be sent in writing to each Active Member of the Medical Staff no less than thirty (30) days prior to the next regular meeting of the Medical Staff. To be adopted, the amendment or revision shall require a two-thirds (2/3) favorable vote of the Active Staff Members present or a two-thirds (2/3) favorable vote of the Active Staff Member responding to the request for approval, should such a request be sent out via mail or email. Amendment or revision so made shall be effective when approved by the Governing Body.⁷⁷ Notwithstanding the foregoing, the Medical Executive Committee may consider and vote to recommend to the Governing Body the approval of revisions or updates to these Bylaws when such revisions are necessary for the Bylaws to be in compliance with applicable laws, regulations, accreditation or certification standards; to meet requirements imposed by a state or deferral entity or agency with jurisdiction over the Hospital or if the proposed revisions do not diminish any Member's rights to exercise their privileges, to due process or a hearing as affirmatively granted in these Bylaws, or diminish any other rights affirmatively granted by these Bylaws to Members. In such situations, the Medical Executive Committee shall submit its recommended revisions to the Bylaws to the Governing Body for the Governing Body's final approval, and also submit its recommended revision to the full Medical Staff with any comments of the Medical Executive Committee at least thirty (30) days prior to any final vote by the Governing Body.

15.2 REQUEST BY MEDICAL STAFF

In addition to the foregoing, an amendment or revision(s) to the Medical Staff Bylaws may be proposed by a petition signed by at least forty (40) percent of the Active Members eligible to vote. Amendments or revisions submitted upon petition of the voting Members shall be provided to the Medical Executive Committee at least thirty (30) days before they are submitted to the Governing Body for review and comment as described in Section 15.1. The Medical Executive Committee has the right to have its comments regarding the proposed amendments or revisions circulated to the Governing Body when the proposed amendments or revisions are submitted to the Governing Body for comments; and to have its comments circulated to the Medical Staff with the proposed amendments or revisions at the time they are distributed to the Medical Staff for a vote.⁷⁸

⁷⁷ MS 01.01.01 EP 1, EP 2, EP 3, and EP 24

⁷⁸ MS 01.01.01 EP 1, EP 2, EP 3, EP8 and EP 24

ARTICLE XVI- MEDICAL RECORDS

16.1 MEDICAL RECORDS

16.1-1 Compliance with Hospital and Medical Staff Policies

Medical Staff Members shall comply with all applicable Hospital and Medical Staff policies, applicable law, regulations, licensure and accreditation standards regarding the content and completion of patient medical records.

16.1-2 Admission History and Physical Examination

A patient admitted for inpatient care shall have a complete admission history and physical examination within twenty-four (24) hours of admission and prior to any procedure. Said history and physical examination shall be the responsibility of a licensed independent practitioner (i.e. physicians, oral and maxillofacial surgeons, dentists, podiatrists, PAs and some ARNPs). Dentists shall be responsible for the part of their patient's history and physical examination that relates to dentistry, and podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry. This report should include all pertinent findings resulting from an assessment of all systems of the body, to include a physical assessment which has been completed within the first twenty-four (24) hours of admission. If a complete history has been recorded and a physical examination performed within thirty (30) days prior to the patient's admission or registration to the Hospital, a reasonably durable, legible copy of these reports may be used in the patient's Hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an update note indicating any changes or no changes to the history and/or physical findings must always be recorded prior to any procedures requiring anesthesia or conscious sedation and within twenty-four (24) hours of admission. An exception to these rules will be granted when the record is prepared by a resident physician or Dependent Healthcare Professional in which instance the attending physician countersigns the record.

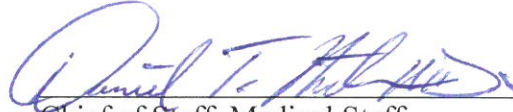
16.1-3 History and Physical Required Prior to Procedure

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

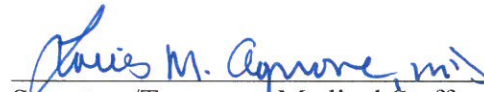
ARTICLE XVII -ADOPTION

These Bylaws shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Governing Body of the Hospital.

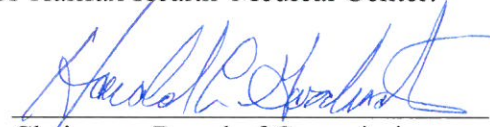
Adopted by the Active Medical Staff of Halifax Health Medical Center.


Chief of Staff, Medical Staff

Date: March, 21, 2017


Secretary/Treasurer, Medical Staff

Approved by the Governing Body of Halifax Health Medical Center.


Chairman, Board of Commissioners

Date: May 1, 2017


Secretary, Board of Commissioners