SGMC HEALTH MAIN

MEDICAL STAFF BYLAWS

2024

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SGMC HEALTH MAIN CAMPUS
MEDICAL STAFF BYLAWS

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PREAMBLE

These Bylaws represent a statement for the conduct of the administrative functions of the Medical Staff in governing itself, Staff Members, and the Medical Staff's relations to the Authority and Administration.

The Medical Staff Bylaws govern the practitioners that are members of the South Georgia Medical Center Inc, d/b/a SGMC Health ("SGMC") Medical Staff to include the SGMC Health main campus and its additional hospital campus known as Smith Northview campus operated under a single license.

CERTAIN DEFINITIONS

"Administration" means the Hospital Administrator and the Administrative Staff of the Hospital Authority.

"Administrator" means the Administrator regularly employed by the Board to act on its behalf in the overall management of the Hospital or anyone to whom the Administrator delegates the function of Hospital Administrator hereunder, with the approval of the Board.

"Allied Health Professional" means an individual licensed in the State of Georgia to specialize in one or more areas of healthcare delivery under the supervision and responsibility of a Physician (such as, but not limited to, physician's assistants, nurse midwives, certified registered nurse anesthetists, etc.). Such persons may not exercise Clinical Privileges but may provide certain direct patient care services and exercise Clinical Functions in the Hospital as provided in these Bylaws.

"Applicant" means a person applying for Medical Staff Membership, Clinical Privileges, or both.

"Applicant for Initial Privileges" means an individual who has completed his/her residency training within the prior six (6) months, who has not commenced a medical practice outside of his/her training, and is applying for Clinical Privileges at the Hospital for the first time.

"Applicant for New Privileges" means an individual applying for Clinical Privileges at the Hospital for the first time; an individual holding Clinical Privileges who is requesting one or more additional Clinical Privileges; and an individual who is in the reappointment process and is requesting one or more additional Clinical Privileges.

"Board" means the Board of Trustees of the Hospital Authority.

"Board Certified" means certified by the applicable specialty or clinical board or boards as defined by the American Board of Medical Specialties or the American Osteopathic Association Bureau of Osteopathic Specialists.

"Bylaws" means the Bylaws of the Medical Staff of the Hospital, unless otherwise specified.

"Chief Executive Officer" means the Chief Executive Officer ("CEO") regularly employed by the Board to act on its behalf in the overall management of the Hospital or anyone to whom the CEO delegates the function of Hospital Chief Executive Officer hereunder, with the approval of the Board.

"Chief of the Medical Staff" or "Chief of Staff" means the Chief Officer of the Medical Staff elected by Staff Members.

"Clinical Functions" means duty or permission to provide one or more direct patient care services in the Hospital at the request or direction, and under the supervision of a Staff Member.

"Clinical Privileges" means the duty or permission to independently provide direct patient care services within well-defined limits, based on the individual's professional license, experience, demonstrated competence, ability and judgment. Clinical Privileges includes full right of access to those Hospital resources, equipment, facilities, and personnel reasonably necessary to effectively provide patient care services.

"Committee" means any standing or special committee or steering council of the Medical Staff or the Hospital.

"Dentist" means any Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) fully licensed by the Georgia Board of Dentistry to practice Dentistry.

"Department" means any clinical department of the Medical Staff.

"Health Care Quality Improvement Act" or "HCQIA" means the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 et seq., as amended from time to time.

"Hospital" means the hospital facility owned and operated by the South Georgia Medical Center Inc, under the name SGMC Health, including Smith Northview Campus.

"Hospital Authority" means the Hospital Authority of Valdosta and Lowndes County, Georgia or the Board of Trustees of the Hospital Authority as the context may require.

"Information" means records of proceedings, minutes, other records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matters.

"Limited License Professional" means an individual, other than a Physician, Oral and Maxillofacial Surgeon or Dentist, who is licensed in the State of Georgia to specialize in podiatry or psychology. To the extent authorized by the Board, Limited

License Professionals may apply for Clinical Privileges and exercise such Clinical Privileges as may be granted pursuant to these Bylaws.

"Medical Director" means the individual serving as a physician-member of the Administration in the dual capacity of Chief Medical Officer and Director of Medical Affairs, pursuant to a position description approved by the Board and the Medical Executive Committee. The Medical Director shall be employed by the Hospital but shall have responsibility for working jointly with the Administrator and the Chief of Staff.

"Medical Staff" or "Staff" means the Physicians, Oral and Maxillofacial Surgeons and Dentists who have been admitted to the Medical Staff of the Hospital in their respective capacities.

"Medical Executive Committee" or "Executive Committee" means the Executive Committee of the Medical Staff, unless otherwise specified. The Medical Executive Committee shall constitute the governing body of the Medical Staff.

"Member in good standing" means a Medical Staff Member who maintains Medical Staff Membership and Clinical Privileges which Membership and Clinical Privileges are not under suspension.

"Officer" means an officer of the Medical Staff, a Departmental officer, or any Staff Member serving in any other elected or appointed office or position.

"Oral and Maxillofacial Surgeon" means any Dentist who has successfully completed a post-graduate oral-maxillofacial surgery program accredited by the American Board of Oral and Maxillofacial Surgery.

"Physician" means any Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is fully licensed in the State of Georgia to practice medicine.

"Practitioner" means:

(a) Any Physician, Oral and Maxillofacial Surgeon or Dentist applying for or exercising Clinical Privileges under these Bylaws;

(b) Such a person who does not exercise Clinical Privileges but who is a Staff Member assigned to the Honorary Staff; or

(c) A Limited License Professional where the Board has authorized the application for and the exercise of Clinical Privileges by such Limited License Professionals.

"Prerogative" means a participatory right granted, by virtue of Staff category or otherwise, to a Staff Member and exercisable subject to the conditions imposed in these Bylaws and in other Hospital Authority and Medical Staff Policies.

"Representative" means any individual authorized by any of the following to perform specific Information gathering or disseminating functions:

(a) The Board and any member or committee thereof;

(b) The Administrator;

(c) The Medical Staff; or

(d) Any Staff Member, Officer, Department, Service, Section or Committee thereof.

"Service" or "Section" means any clinical specialty within a Department.

"Staff Member" means a member of the Medical Staff.

"Staff Membership" means the status of being a Staff Member.

ARTICLE I - NAME

The name of these Bylaws shall be the Bylaws of the Medical Staff of SGMC Health Main Campus.

ARTICLE II - PURPOSE

A. The primary purpose for the Medical Staff and these Bylaws is to provide the organizational framework within which to:

1) Initiate, maintain and enforce rules and regulations for self-governance of the Medical Staff and accountability to the Hospital Authority;

2) Provide oversight of care, treatment and services provided by Practitioners exercising Clinical Privileges in the Hospital;

3) Provide a uniform quality of patient care, treatment and services for those patients admitted to or treated in or by any of the facilities, Departments, or services of the Hospital Authority, consistent with resources locally available;

4) Provide means for orderly and non-disruptive discussions and solutions of issues concerning the provision of professional services in the Hospital, including, without limitation, Staff Membership and Clinical Privilege decisions, cost containment decisions, utilization review decisions, clinical aspects of Hospital Authority employee performance and the quality and efficiency of patient care delivered in the Hospital; and

5) Foster a high level of professional performance and ethical conduct of its members and affiliates through appropriate delineation of the Clinical Privileges that each Practitioner may exercise in the Hospital and through an ongoing evaluation and review of each Practitioner's performance in the Hospital.

6) Provide that in the event that questions or concerns were to arise regarding the application and/or interpretation of these By-laws, or any Rule or Regulation, Policy or Procedure or other pronouncement from the Medical Staff or its officers, arising under these By-laws, such questions or concerns shall be addressed by the Medical Executive Committee, after consultation with counsel.

B. The purposes for promulgating these Bylaws do not include the establishment of a higher standard of patient care than that otherwise required by law.

C. The Medical Staff is a constituent part of the Hospital and is not a separate entity. These Bylaws do not constitute a contract between the Hospital Authority and any Staff Member or Practitioner.

ARTICLE III - MEDICAL STAFF MEMBERSHIP

A. Nature of Membership

Staff Membership confers privileges and Prerogatives, but only as stated in these Bylaws. Staff Membership shall be extended only to those professionally competent Physicians, Oral and Maxillofacial Surgeons and Dentists as are deemed by the Staff and the Board to be necessary for the proper care and treatment of patients. A Staff Member is neither an employee nor an independent contractor of the Hospital Authority by virtue of these Bylaws. Except as specifically agreed to by contract between the Hospital Authority and a Practitioner, Medical Staff Membership shall be granted, modified or terminated only for reasons directly related to the delivery of quality patient care or for other reasons specified in these Bylaws and only according to the procedures outlined in these Bylaws. The Hospital Authority hereby delegates to the Chief Executive Officer the authority to sign and execute any and all medical staff appointments, letters and approved actions of the Hospital Authority related to Medical Staff matters.

B. Threshold Criteria for Membership

1) Except as otherwise provided in these Bylaws, to be eligible to apply for initial appointment or reappointment to the Medical Staff, other than the Honorary Staff, an individual must:

a) Be a Physician, Oral and Maxillofacial Surgeon or Dentist;

b) Have a current, unrestricted license to practice in Georgia and have never had a license to practice denied, restricted, revoked or suspended by any state licensing agency, have never agreed not to exercise a license to practice in any state or not to reapply for such a license to avoid a restriction, revocation, suspension, or denial, and have never withdrawn an application for a license to practice in any state in order to avoid denial of such a license;

c) Where applicable to his or her practice, have a current, unrestricted Georgia DEA registration;

d) If applying for Active Staff Membership (other than in the Emergency Medicine Services, maintain a functional office within Lowndes County, Georgia, and a residence within a thirty-minute drive (legal driving speed) of the Hospital;

e) Have current, valid professional liability insurance coverage in a form and in amounts not less than One Million dollars ($1,000,000) per occurrence and Three Million dollars ($3,000,000.00) in the aggregate, as adopted by the Board from time to time after consultation with the Medical Executive Committee;

f) Have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payor fraud or program abuse, nor have been required to pay civil penalties for the same;

g) Have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental healthcare programs;

h) Have never had medical staff appointment or clinical privileges denied, restricted, revoked, relinquished, or terminated by any healthcare facility or health plan for reasons related to clinical competence or professional conduct and have never agreed not to exercise clinical privileges or not to reapply for medical staff membership or clinical privileges at any hospital or facility to avoid denial, restriction, revocation, suspension, or termination of medical staff membership and/or clinical privileges, and have never withdrawn an application for medical staff membership and/or clinical privileges at any hospital or facility to avoid denial of such membership or clinical privileges;

i) Have never been convicted of, or entered a plea of guilty or no contest to any misdemeanor relating to controlled substances, illegal drugs, insurance or healthcare fraud or abuse or violence, or any felony;

j) If applying for Active Staff Membership, agree to fulfill all responsibilities regarding emergency call;

k) If applying for Active Staff Membership, have or agree to make coverage arrangements with other Staff Members for those times when the individual will be unavailable;

l) If the individual is a Doctor of Medicine:

i) Who obtained his/her M.D. degree in the United States or Canada must have demonstrated that the individual graduated from a school of medicine accredited by the Liaison Committee on Medical Education or the Committee for Accreditation of Canadian Medical

Schools, as applicable, and meets the requirements of the applicable Service or Section contained in Article IX, C., of these Bylaws. (This requirement is only applicable to those individuals who apply for Staff Membership on or after January 1, 1999); or

ii) Who obtained his/her M.D. degree outside of the United States, must have demonstrated that the individual received Certification by the Educational Commission for Foreign Medical Graduates ("ECFMG") and that he/she meets the requirements of the applicable Service or Section contained in Article IX, C., of these Bylaws. (This requirement is only applicable to those individuals who apply for Staff Membership on or after February 20, 2012).

m) If the individual is a Doctor of Osteopathy: have demonstrated that the individual graduated from a college of osteopathic medicine accredited by the American Osteopathic Association and meets the requirements of the applicable Service or Section contained in Article IX, C. of these Bylaws. (This requirement is only applicable to those individuals who apply for Staff Membership on or after January 1, 1999); or

n) If the individual is an Oral and Maxillofacial Surgeon or a Dentist, have demonstrated that the individual's education and training meets the requirements of the applicable Service or Section contained in Article IX, C. of these Bylaws. (This requirement is only applicable to those individuals who apply for Staff Membership on or after January 1, 1999);

o) Have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education[1] or the American Osteopathic Association[2] in a specialty in which the individual seeks Clinical Privileges or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association. If the individual is a resident, they must meet the requirements of Article IV F. 2) d).";

p) If required by this Article III to be Board Certified, maintain such Board Certification and, to the extent required by the applicable specialty/sub-specialty certifying board, satisfy recertification requirements. Recertification will be assessed at reappointment. (This requirement is applicable only to those individuals who apply for initial Staff appointment on or after January 1, 2006.); and

[1] Applicable only to those individuals who apply for initial Staff appointment on or after January 19, 2005.
[2] Applicable only to those individuals who apply for initial Staff appointment on or after January 1, 2012.

q) Comply with the applicable Conditions of Participation, as promulgated by the Centers for Medicare and Medicaid Services ("CMS") and applicable to the Hospital and the facilities served by the Medical Staff.

2) After January 1, 2012, those individuals who are not Board Certified at the time of appointment as required by this Article III, but who have completed their residency training within the last six (6) years shall be eligible for Staff appointment. However, in order to remain eligible for appointment, those individuals must achieve Board Certification or meet the training and experience and any time limit requirements for such certification within six (6) years from the date of completion of approved post-graduate training.

3) Applicants for Initial Privileges who meet all Threshold Criteria for Membership other than Article III, B.(1)(b) (Georgia licensure), B.(1)(c) (Georgia DEA registration), and B.(1)(e) (professional liability insurance coverage), are eligible to apply for initial appointment to the Medical Staff, pending the Medical Staff's receipt of documentation of satisfaction of such Threshold Criteria.

C. Effect of Other Affiliations

No individual shall be automatically entitled to Staff Membership merely because he or she:

1) Is licensed to practice in this or any other state;

2) Is a member of any professional organization;

3) Is certified by any specialty or clinical board; or

4) Had, or presently has, staff membership or clinical privileges at another healthcare facility or in another practice setting.

D. Prohibited Criteria

Staff Membership shall not be granted or denied on the basis of race, color, religion, sex, disability, national origin, handicap, or age, and shall not be granted or denied arbitrarily, capriciously or on any unlawful or irrational basis.

E. Responsibilities

Each Staff Member shall:

1) provide his or her patients with care at the generally recognized professional level of quality and efficiency applicable to Practitioners practicing at the Hospital;

2) abide by the Bylaws, Policies, and Rules and Regulations of the Staff and the Hospital Authority, as the same may be amended from time to time;

3) discharge such Staff, Department, Committee and Hospital Authority functions for which he or she is responsible by appointment, election, or otherwise;

4) prepare and complete in a timely manner the medical and other records that are essential for providing quality patient care to all patients he or she admits or to whom he or she in any way provides care in the Hospital;

5) abide by the ethical principles of his or her profession;

6) comply with all applicable laws and regulations; and

7) cooperate with the Medical Executive Committee, the Administration and the Board on matters relating to patient care and the orderly operation of the Hospital, in keeping with sound quality patient care and business practices.

8) comply with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and shall not use or disclose patient information in violation of the applicable state and federal laws and the policies applicable to SGMC and its facilities. Practitioner shall be solely responsible for the security of his or her password and user id. Practitioner shall not share or disclose his or her unique user id or password to any individual or entity. A violation of this requirement, the applicable laws or applicable policies may result in an adverse professional review action, including, but not limited to immediate suspension of access to the SGMC patient clinical records or adverse actions related to practitioner's privileges.

9) while providing emergency department call coverage, as applicable for the Staff Member's membership, category, duties, specialty or privileges, as described herein, Staff Member shall be immediately available by page and telephone to the Emergency Department, and if contacted by an Emergency Department physician and requested to come to the Emergency Department to examine or treat a patient, Staff Member shall come to the Emergency Department within thirty (30) minutes of the request unless the Emergency Department physician defines a later time period. The Emergency Department physician will determine whether the patient's condition requires Physicians to see the patient in the Emergency Department. The determination of the Emergency Department physician controls.

ARTICLE IV - CATEGORIES OF THE MEDICAL STAFF

A. The Active Medical Staff

1) Qualifications

The Active Medical Staff ("Active Staff") shall consist of Physicians, Oral and Maxillofacial Surgeons and Dentists (whether independent practitioners or employed or contracted by the hospital) who:

a) meet the Threshold Criteria for Membership set forth in Article III;

b) have been granted Staff Membership and Clinical Privileges as provided in these Bylaws;

c) are regularly responsible for patient care in the Hospital, and, except for contract Physicians, whose written agreement with the hospital provides otherwise, maintain a functional office and residence within Lowndes County or within a thirty-minute drive (legal driving speed) of the Hospital; and

d) have advanced from provisional status pursuant to Article IV, B. below; and

2) Duties

All Active Staff Members shall belong to a specific Department and Service and are required to attend Staff meetings and fulfill all obligations set forth in these Bylaws, including:

a) assuming all the functions and responsibilities of appointment to the Active Staff, including care for unassigned patients, emergency service obligations and consultation unless an employed or contracted physician's agreement with the hospital provides otherwise; provided, however, upon reaching age sixty (60), an Active Staff Member in good standing shall have the option to apply for a waiver from Active Staff Member's duty to provide emergency backup call, duty to serve on committees of the Staff and Departments, or such other duties as approved by the Executive Committee and the Board;

b) attending applicable meetings;

c) serving on Staff Committees, as assigned;

d) faithfully performing the duties of any office or position to which elected or appointed;

e) participating in performance improvement, monitoring and peer review activities as may be assigned by Department Chairs or Committees; and

f) to the extent the provider is serving as faculty, participating in the Hospital's medical education and training programs, including, without limitation, residency program training and medical student education and graduate medical education training programs, as a preceptor, faculty member or supervising physician under the Hospital's medical and education training program or in accordance with the Hospital's ACGME Accreditation, medical school affiliations and graduate medical education programs.

3) Prerogatives

All Active Staff Members shall be eligible to:

a) admit patients (except to the extent that Contract Physician's written agreement with the hospital provides otherwise);

b) exercise Clinical Privileges as specifically granted pursuant to these Bylaws;

c) vote (unless the Physician is a Contract Physician who does not work in the Hospital on a full-time basis (at least one hundred and twenty (120) hours per month);

d) hold office; and

e) serve on Committees.

4) Special Provisions Regarding Employed or Contracted Physicians

a) Generally, the terms of these By-Laws (and related Medical Staff Policies and/or Rules and Regulations) supersede any Contract of Employment or for Independent Contract Medical Services except in regard to:

i. ER and "follow-up call" responsibilities (as specified in the respective agreement of employed or contracted physicians);

ii. Where such Service Agreement provides that upon an expiration or termination of such agreement that Medical Staff Membership of such member terminate (or that the Medical Staff Membership of an individual physician providing services through a contracted-group be terminated upon that physician no longer performing services at the Hospital under the agreement), then the termination shall be administratively effective in accordance with the terms of the Service Agreement. Such Administrative Termination shall not be deemed to be an adverse action under the Bylaws and shall occur without any hearing or procedural rights for Medical Staff members providing services under such a contract regardless of whether the Medical Staff member signed such Agreement.

iii. Any such employed or contract physician described in sub-section above, who desires to continue to serve as an independent active staff physician (for a service that is not covered by an exclusive contract), may request to do so.

b) For Employed or Contracted Physicians that provide services on behalf of the SGMC Physician Network, Inc., which is an

independent affiliate of the Hospital, SGMC Physician Network, Inc. may contract with the SGMC Medical Staff to provide the credentialing or qualification review required for managed care entities that contract with SGMC Physician Network, Inc. Any delegated credentialing services provided by the SGMC Medical Staff shall be documented through a separate contractual agreement and shall be performed on an as needed basis. The delegated credentialing services shall be limited solely to the services described by the delegated credentialing services agreement.

B. Provisional Status

1) Duration

Unless specifically waived by the Board, all initial appointments to the Active Staff shall be provisional for the term of the initial appointment and may be extended for additional one (1) year terms pursuant to Article IV, B.(5) below, not to exceed a maximum total of four (4) years.

2) Duties

Each Staff Member on provisional status shall attend meetings of the Staff and the Department and Service of which he or she is a member, including open Committee meetings and educational programs, in the same manner as regular members of his or her appropriate Staff category. During the first year, the provisional status Staff Member shall have no right to vote at such meetings, except within Committees when the right to vote is specified at the time of appointment. During the second year, the provisional status Staff Member shall have the right to vote at such meetings unless he/she is a member of the Emergency Medicine Services and does not work in the Hospital Emergency Department on a full-time basis (one hundred and twenty (120) hours per month). The provisional status Staff Member shall perform other duties in the same manner as regular members of the Active Staff. The provisional status Staff Member shall not be eligible to serve as chairman of any Committee or to serve on the Medical Executive Committee or the Professional Qualifications Committee.

3) Prerogatives

Each provisional status Staff Member shall be entitled to exercise the Prerogatives as may be exercised by regular members of the Active Staff category. Provisional status Staff Members shall not be eligible to hold Staff office.

4) Evaluation of Staff Members on Provisional Status

Each provisional status Staff Member shall undergo a period of evaluation as described in Article VI, E. In addition to the purposes described in Article VI, E., in the case of a provisional Staff Member, the purpose of the period of evaluation

shall be to evaluate the provisional Staff Member's proficiency in the exercise of Clinical Privileges initially granted, overall eligibility for continued Staff Membership and advancement to regular status within the Active Staff.

5) Extended Term of Provisional Status

The provisional status of a Staff Member may be extended by the Board for additional one (1) year terms, not to exceed a maximum of four (4) years of provisional status. The Board shall consider the issue of advancement from provisional status to regular status during its review of an application for reappointment following expiration of initial appointment and in connection with any expiring term of provisional status appointment.

6) Action at Conclusion of Provisional Status

At the end of any provisional status appointment:

a) The Chairman of each Department to which the Staff Member is assigned shall report to the Professional Qualifications Committee, whether the Staff Member has satisfactorily demonstrated, through the evaluation process provided for in Article IV, B.(4), his or her ability for continued Staff Membership. The report shall specifically address whether sufficient treatment of patients has occurred to properly evaluate the Clinical Privileges being exercised.

b) The Professional Qualifications Committee shall make a recommendation to the Medical Executive Committee stating whether the provisional status Staff Member is eligible for regular status on the Active Staff or if not, if the Staff Member is eligible for another term of provisional status, whether the provisional Staff Member should be reappointed to another one (1) year term of provisional status.

c) The Medical Executive Committee shall either: (i) adopt the recommendation of the Professional Qualifications Committee; (ii) send the application back to the Professional Qualifications Committee with specific concerns or questions, or (iii) make a recommendation different than the Professional Qualifications Committee. The Medical Executive Committee's recommendation is forwarded to the Board.

d) The Board shall either: (i) adopt the Medical Executive Committee's recommendation as its decision, (ii) send the application back to the Medical Executive Committee with specific concerns or questions, or (iii) make a decision different from the Medical Executive Committee.

Neither the recommendation of the Medical Executive Committee nor the decision of the Board shall be subject to review pursuant to Article XII unless the recommendation or decision is adverse to the Staff Member as defined in Article

XII, in which case the Staff Member shall be entitled to the hearing and appeal procedures provided in Article XII.

C. The Consulting Medical Staff

1) Qualifications

Any Staff Member in good standing may consult in his or her area of expertise; however, the Consulting Medical Staff ("Consulting Staff") shall consist of such Physicians, Oral and Maxillofacial Surgeons and Dentists who:

a) possess skills not readily available from a current Staff Member;

b) are not otherwise Staff Members but meet the Threshold Criteria for Membership set forth in Article III, except that this requirement shall not preclude any out-of-state Physician, Oral and Maxillofacial Surgeon or Dentist from appointment as may be permitted by law if that individual is otherwise deemed qualified by the Medical Executive Committee, subject to approval by the Board;

c) have been granted Clinical Privileges as provided in these Bylaws;

d) possess adequate clinical and professional expertise;

e) are willing and able to come to the Hospital on schedule or promptly respond when called to render clinical services within their area of competence; and

f) are members of the active, associate or provisional medical staff of another hospital licensed by the State of Georgia or another State, although exceptions to this requirement may be made by the Board for good cause.

2) Prerogatives

The Consulting Staff Member shall:

a) have consultation privileges, but shall not have privileges for admitting patients for emergency room, or inpatient/outpatient care;

b) be entitled to exercise such Clinical Privileges as are granted pursuant to these Bylaws; and

c) be entitled, but not required, to attend meetings of the Staff and the Department of which that person is a member, including open Committee meetings and educational programs, but shall have no right to vote at such meetings, except within Committees when the right to vote is specified at the time of appointment.

Consulting Staff Members shall not be eligible to hold Staff office, but may serve upon Committees.

D. The Honorary Medical Staff

1) Qualifications

The Honorary Medical Staff ("Honorary Staff") shall consist of Physicians, Oral and Maxillofacial Surgeons and Dentists who are recognized for their noteworthy contributions to patient care, their outstanding reputations, and/or their long-standing service to the Medical Staff and the Hospital Authority. Applicants for this category of Staff Membership are eligible upon reaching the age of sixty-five (65) or upon written request to the Chief of Staff upon reaching the age of sixty (60). Applicants need not meet the Threshold Criteria for Membership set forth in Article III, B., nor need they complete the provisional status period provided in Article IV, B.

2) Prerogatives

Honorary Staff Members shall not be eligible to admit patients, to exercise Clinical Privileges, to vote, or to hold office. They may, but are not required to, attend Staff and Department meetings, including open Committee meetings and educational programs. They may, but are not required to, serve on standing Committees. Honorary Staff Membership is a lifetime appointment and no reappointment is required.

E. The Telemedicine Staff

1) Definition of Telemedicine Privileges

a) "Telemedicine Privileges" means the authorization granted by the Board to a member of the Telemedicine Staff to render a diagnosis or otherwise provide clinical treatment to a patient at the Hospital through the use of electronic communication or other communication technologies. Telemedicine Privileges are only granted to members of the Telemedicine Staff. Members of other Staff categories need not be granted Telemedicine Privileges in order to render diagnosis or care by electronic means.

b) After considering the recommendations of the Chiefs of the relevant Services, the Medical Executive Committee shall make a recommendation to the Board regarding the clinical services that should be offered through Telemedicine Privileges.

2) Qualifications

a) Telemedicine Staff shall consist of Physicians who live and practice outside of the Hospital's service area and hold a current, valid Georgia license to practice medicine.

b) These Physicians must have comparable qualifications, hold comparable liability insurance, and shall submit an application and achieve approval by the same appointment evaluation process as Active Staff Members.

c) The Hospital may enter into a written agreement with the distant site to use the Information regarding the Physicians' qualifications and competency from the distant site if all of the following requirements are met:

1) the distant site is accredited by The Joint Commission;
2) the Physician maintains clinical privileges at the distant site for those services to be provided at the Hospital;
3) the distant site provides a list of Physician's current privileges at the distant site;
4) the distant site is either a Medicare-accredited hospital or an entity which as in place a credentialing and privileging process which meets the standards of the Medicare Conditions of Participation; and
5) the Hospital has evidence of an internal review of the Practitioner's performance of these clinical privileges and sends to the distant site Information that is useful to assess the Physician's quality of care, treatment, and services for use in the appointment of clinical privileges and performance improvement. At a minimum, this Information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided, and complaints about the distant site Physician from patients, physicians, or staff at the Hospital. This occurs in a way consistent with any Hospital or Medical Staff policy or procedures intended to preserve any confidentiality or privilege of Information established by applicable law.

3) Limitations

a) Telemedicine Staff Members shall only exercise Telemedicine Privileges as granted pursuant to these Bylaws.

b) Telemedicine Staff shall not be eligible to admit or attend patients in the Hospital, to hold office, or serve on any Medical Staff Committees.

c) Telemedicine Staff shall not be required to attend meetings or participate in the Emergency Department or other specialty coverage service.

F. The Hospitalist and Specific Need Contract Staff

1) Qualifications - Hospitalists and Specific Need Contractors

Physicians who function as Hospitalists or who are contracted by the Hospital to meet a Specific Need must meet the Threshold Criteria for Membership of the Service and Department in which they practice. These physicians must apply for and be granted privileges in the same manner as other members of the Medical Staff as set forth in Article III. These Physicians must reside within Lowndes County, Georgia or within a thirty-minute drive (legal driving speed) of the Hospital while on duty as a Hospitalist or Specific Need Contractor.

2) Duties

a) Practitioners in this Category carry the same obligations as other members of their Service/Department.

b) Practitioners in this Category are expected to attend Staff and Department meetings, serve on Committees when eligible and comply with other duties and requirements of Staff Membership including but not limited to:

i. faithfully performing the duties of any office or position to which elected or appointed; and
ii. participating in performance improvement, monitoring and peer review activities as may be assigned by Department Chairs or Committees.

c) Emergency Department Backup and Post-Discharge Follow-up Duties

i. **Hospitalists:** Since Hospitalists are available for admissions of unattached patients and for consultations and admissions of other patients at the request of other physicians, Hospitalists are not required to participate in the Emergency Department back-up roster with other members of the Service/Department in which they practice, nor do they perform follow-up visits following discharge unless an exception is recommended by the Medical Executive Committee and approved by the Hospital Authority.

iii. **Specific Need Contractors**: The duties of Specific Need Contract Physicians as to the Emergency Back Up Roster and in regard to Post-Discharge Follow Up Care shall be as specified in the Provider's Contract with the Authority.

d) As it relates to Emergency Room Residents those individuals shall

be considered a special class of "Specific Need Contractors" subject to the restrictions on their practice found at Article IX, Section C(1)(m) of the MEC Bylaws requiring that they work under the direct supervision of an Active Staff Member of the Emergency Medicine Service and the quality of their work continues to be monitored by the Medical Director of the Emergency Medicine Service.

3) Prerogatives

Except as otherwise provided, all Hospitalist Staff Members shall be eligible to:

a) admit patients;

b) exercise Clinical Privileges as specifically granted pursuant to these Bylaws;

c) serve on Committees.

e) vote and hold office only if:

i. the Practitioner maintains his or her PRIMARY residence within a thirty-minute drive (legal driving speed) of the Hospital; and

ii. he/she works as a Hospitalist in the Hospital or as a Specific Need Contract Physician providing treating patients in the Hospital on a full-time basis (at least fifteen (15) shifts per month or two (2) weeks per month)

4) Special Limitation on Contract Services

In the event of any inconsistency in the Medical Staff Bylaws (together collectively with the underlying Medical Staff Policies and Rules and Regulations) and in the Service Agreement pursuant to which a Hospitalist or Specific Need Contract Physician provides care to Hospital patients, the terms of the Service Agreement shall not supersede the Medical Staff Bylaws except as permitted under these Bylaws. Where such Service Agreement provides that upon an expiration or termination of such agreement that Medical Staff Membership of such member terminate (or that the Medical Staff Membership of an individual physician providing services through a contracted-group be terminated upon that physician no longer performing services at the Hospital under the agreement), then the termination shall be administratively affected in accordance with the terms of the Service Agreement. Such Administrative Termination shall not be deemed to be an adverse action under the Bylaws and shall occur without any hearing or procedural rights for Medical Staff members providing services under such a contract regardless of whether the Medical Staff member signed such Agreement.

G. The Coverage Medical Staff

1) Qualifications

The Coverage Medical Staff ("Coverage Staff") shall consist of Physicians who:

a) Are not otherwise Staff Members, but meet the Threshold Criteria for Staff Membership; and

b) Possess adequate clinical and professional expertise; and

c) Are: (i) members of the Active Medical Staff of another licensed hospital accredited by a hospital accreditation organization approved by the U.S. Centers for Medicare and Medicaid Services ("CMS") or a U.S. Military Hospital; or (ii) currently enrolled in a fellowship program at another licensed hospital accredited by a hospital accreditation organization approved by CMS; and

d) Have provided *locum tenens* coverage or intend to provide recurring *locum tenens* coverage for a member(s) of the Active Staff: (i) more than seventy-five (75) days during any one (1) calendar year; or (ii) who require more than two (2) separate appointments of Temporary Clinical Privileges as a *locum tenens* during any one calendar year; and

e) At appointment and each reappointment, provide evidence of clinical performance at their primary hospital in such form as may be requested, and if requested, such other information as may be requested in order to perform an appropriate evaluation of qualifications; and

f) Do not live or maintain a permanent and functional office for the practice of medicine or dentistry and consultation with patients within thirty (30) minutes, (legal driving speed), of the Hospital.

2) Responsibilities and Prerogatives

Coverage Staff Members:

a) Shall assume all functions and responsibilities required to provide coverage for the applicable Staff Member(s), including where appropriate, care for patients, emergency service care and consultations; and

b) May attend meetings of the Medical Staff and applicable Departments (all without a vote); and

c) Shall cooperate with performance improvement, monitoring, medical review and peer review activities, including responding fully and timely to any inquiries regarding the care of patients at the Hospital.

3) Limitations

Coverage Staff Members:

a) May not hold office or serve on Committees; and

b) May not vote.

H. The JMS Burn Center Medical Staff

1) Qualifications

The JMS Burn Center Medical Staff ("Burn Center Staff") shall consist of Physicians who:

a) Provide surgical services as employees or contractors of the Joseph M. Stills Burn Center, Inc.;

b) Are not otherwise Staff Members, but meet the Threshold Criteria for Staff Membership;

c) Possess adequate clinical and professional expertise in the treatment of burn victims;

d) Are members of the Active Medical Staff of Doctors Hospital, Augusta, Georgia; and

e) At appointment and each reappointment, provide evidence of clinical performance at their primary hospital in such form as may be requested, and if requested, such other information as may be requested in order to perform an appropriate evaluation of qualifications.

2) Responsibilities and Prerogatives

Burn Center Staff Members:

a) Shall assume all functions and responsibilities required to provide care and treatment of patients of Burn Center Staff Members;

b) Shall, when on-site, upon request, provide consultations as requested by Staff Members;

c) May attend meetings of the Medical Staff and applicable Departments (all without a vote); and

d) Shall cooperate with performance improvement, monitoring, medical review and peer review activities, including responding fully and timely to any inquiries regarding the care of patients of Burn Center Staff Members.

3) Limitations

Burn Center Staff Members:

a) May not hold office; and

b) May not vote.

I. Occupational Medicine Staff

1) Qualifications

The Occupational Medicine Staff shall consist of Physicians who:

a) Meet the Threshold Criteria for Membership as set forth in Article III;

b) Are actively employed by the Hospital to work exclusively at an off-campus clinic;

c) Are not otherwise Staff Members;

d) Belong to and meet the qualifications for one (1) of the following services:

i) Internal Medicine;

ii) Family Practice; or

iii) Emergency Medicine.

2) Responsibilities and Prerogatives

Members of the Occupational Medicine Staff:

a) Shall exclusively provide services and treatment at the off-campus clinic to which they are assigned;

b) May accept Emergency Department follow-up assignments;

c) Shall not be required to fulfill any Emergency Department call obligations;

d) May refer patients to members of the Staff for admission and/or treatment;

e) May order Hospital outpatient diagnostic tests; and

f) May attend meetings of the Medical Staff (without vote).

3) Limitations

Members of the Occupational Medicine Staff:

a) May not vote;

b) May not hold office;

c) May not be granted Hospital Clinical Privileges and may not admit or treat patients at the Hospital; and

d) May not serve on Committees.

J. The Affiliate Medical Staff

1) Qualifications

The Affiliate Medical Staff ("Affiliate Staff") shall consist of Physicians who:

a) Desire to be associated with the Hospital, but do not intend to establish or maintain a practice at the Hospital;

b) Are not otherwise Staff Members, but meet the Threshold Criteria for Membership;

c) Possess adequate clinical and professional expertise; and

d) Shall provide information as may be requested in order to perform an appropriate evaluation of qualifications (including, but not limited to information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2) Responsibilities and Prerogatives

Affiliate Staff Members:

a) May provide History and Physicals for patients who are admitted for

inpatient or outpatient Hospital services, with appropriate updates by attending physicians;

b) May attend meetings of the Medical Staff and applicable Departments;

c) May serve on Committees; but not on Peer Review Committees;

d) May refer patients to members of the Staff for admission and/or treatment;

e) May visit their patients when hospitalized and review their medical records, but may not write orders or make medical record entries or actively participate in the provision or management of care to patients;

f) Are permitted to order outpatient Hospital diagnostic services; and

g) Are permitted to give medications and medications required specific to outpatient infusions, subject to the Hospital Pharmacist review of such order prior to dispensing such medication.

3) Limitations

Affiliate Staff Members:

a) May not be granted Hospital Clinical Privileges and may not admit or treat patients at the Hospital;

b) May not vote;

c) May not serve as a Department Officer (Department Chairman or Vice Chairman);

d) May not serve as Chief of Staff, Vice Chief, or Secretary/Treasurer; and

e) May not serve as a member of the Medical Executive Committee.

ARTICLE V - CLINICAL PRIVILEGES AND FUNCTIONS

A. Clinical Privileges Restricted

Every Practitioner who is permitted by law and by the Board to provide patient care services independently in the Hospital shall be entitled to exercise only those Clinical Privileges specifically granted to him or her in accordance with these Bylaws. Except as may be specifically agreed to in a contract between the Hospital Authority and a Practitioner, Clinical Privileges shall be granted, modified, or terminated only for reasons directly related to the quality of patient care or for other specific reasons included in these Bylaws, and only according to the procedures outlined in these Bylaws.

B. Criteria

1) Prohibited Criteria

Subject to the provisions of Article V, B.(2), Clinical Privileges shall not be granted or denied on the basis of race, color, religion, sex, national origin, disability or age, and shall not be granted or denied arbitrarily, capriciously or on any unlawful or irrational basis.

2) Permitted Criteria

No professional license whatsoever shall confer any constitutional or other right to practice that profession in the Hospital. The Hospital Authority shall have the right to deny Clinical Privileges to any class of Practitioners who are licensed by the State of Georgia, so long as such exclusion has a rational basis and is reasonably related to the operation of the Hospital or is reasonably related to the health of any individual. Clinical Privileges also may be granted or denied on the basis of statutory, regulatory, or judicial authority or other requirements specifically described in these Bylaws, including, but not limited to, professional liability insurance.

3) Development of Clinical Privileges Criteria

Criteria for Clinical Privileges will be developed as defined in Medical Staff Policy MS #13 as adopted and amended from time to time.

C. Temporary Clinical Privileges

1) Pending Initial Application

With the written concurrence of the Administrator or his or her designee and the Chief of Staff or his or her designee, Temporary Clinical Privileges for an Applicant for New Privileges who meets the Threshold Criteria for Membership as set forth in Article III, B., above, and has submitted a complete application (as defined in Article VI, A. of these Bylaws) may be granted while awaiting review and approval by the Professional Qualifications Committee, the MEC, or the Board, upon verification of the following: current licensure; relevant training and experience; current competence; ability to perform the Clinical Privileges requested; query and evaluation of the National Practitioner Data Bank information; no current or previously successful challenge to licensure or registration; no subjection to involuntary termination of medical staff membership at another organization; and no subjection to involuntary limitation, reduction, denial or loss of Clinical Privileges. Such Temporary Clinical Privileges may be granted for time periods not to exceed thirty (30) days each, and not to exceed a total of one hundred twenty (120) days.

2) When Required for Important Patient Care Need

Temporary Clinical Privileges granted to fulfill an important patient care, treatment or service may be granted for care of specific patients, for *locum tenens* Practitioners, and for specific need. Subject to the additional requirements of subsection (a), (b) or (c) below, with the written concurrence of the Administrator or his or her designee and the Chief of Staff or his or her designee, Temporary Clinical Privileges may be granted to a Practitioner who has submitted a complete application (as defined in Article VI, A.) and who meets the Threshold Criteria for Membership as set forth in Article III, B., above to fulfill an important patient care, treatment or service need including the following circumstances (subsections (a), (b), and (c) below), upon verification of the following: current licensure; relevant training and experience; current competence; ability to perform the Clinical Privileges requested; a query and evaluation of the National Practitioner Bank Information; no current or previously successful challenge to licensure or registration; no subjection to involuntary termination of medical staff membership at another organization; no resignation while under investigation; and no involuntary limitation, reduction, loss or denial of clinical privileges.

a) Care of Specific Patients

A Practitioner may be granted Temporary Clinical Privileges pursuant to this Article V, C (2) for the care of one or more specific patients, limited to those Clinical Privileges in which the Applicant has demonstrated sufficient education, training and ability as determined by the appropriate Department or Departments. Such Temporary Clinical Privileges shall be restricted to the treatment of not more than six (6) patients in any one year by such Practitioner, after which such Practitioner shall be required to apply for Staff Membership or non-temporary Clinical Privileges before being allowed to attend any additional patients. Such Temporary Clinical Privileges shall cease upon the discharge from the Hospital of the specific patients.

b) *Locum Tenens*

A Practitioner may be granted Temporary Clinical Privileges as a *locum tenens* for a Staff Member pursuant to this Article V, C.(2). Procedures required for Practitioners to apply for Temporary Clinical Privileges as a *locum tenens* and the responsibilities of Staff Members who have *locum tenens* coverage are defined in Medical Staff Policy, MS 7, *Locum Tenens.* Temporary *Locum Tenens* Clinical Privileges may be granted for time periods not to exceed sixty (60) days each and may be renewed for additional time periods, provided that Temporary *Locum Tenens* Clinical Privileges shall not exceed seventy-five (75) days during any calendar year and shall not exceed the need for the Practitioner's services as a *locum tenens*. While exercising Temporary *Locum Tenens* Clinical Privileges, *locum tenens* Physicians shall be available within Lowndes County or within a thirty (30) minute drive (legal driving speed) of the Hospital.

c) Temporary Clinical Privileges for Specific Need

With approval of a majority of the members in attendance at a properly constituted meeting of a specific Service or Section or the Medical Executive Committee, a duly licensed Practitioner, may be granted Temporary Clinical Privileges pursuant to Article V, C.(2) for an important patient care, treatment or service need not otherwise addressed by subsections (a) or (b) above. Specific limited Clinical Privileges granted pursuant to this subsection (c) shall be exercised only in accordance with any specific guidelines that the Section or Service may deem necessary and appropriate to assure continuous quality patient care, provided such guidelines are not capricious and arbitrary. Such Temporary Clinical Privileges may be granted for a specific period of time as recommended by the Service or Section not to exceed one hundred twenty (120) days. After the initial period, the Privileges may only be extended by the Medical Executive Committee only in the event of emergencies.

3) Conditions

In the exercising of Temporary Clinical Privileges, the Practitioner shall act under the supervision of the Medical Executive Committee and the appropriate Department. Special requirements of supervision and reporting may be imposed by the Department or the Medical Executive Committee on any Practitioner granted temporary Clinical Privileges. Temporary Clinical Privileges shall be immediately terminated by the Administrator or his or her designee with the concurrence of the Chief of Staff or his or her designee upon a notice from the Chairman of the appropriate Department or the Chief of Staff of any failure of the Practitioner to comply with such special conditions.

4) Termination

On the discovery of any Information or the occurrence of any event which raises a material question as to the Practitioner's professional qualifications or professional ability to exercise any or all of the Temporary Clinical Privileges granted, the Administrator (with the concurrence of the Chief of Staff or his or her designee) may terminate any or all of such Practitioner's Temporary Clinical Privileges, provided that where the life or well-being of a patient under the care of the Practitioner is determined to be endangered by the continued treatment by the Practitioner, termination may be effectuated by any person, Committee or Board entitled to impose precautionary suspension under Article XI, C. In the event of such termination, the Practitioner's patients then in the Hospital shall be assigned to an Active Staff Member by the Chief of Staff in consultation with the relevant Department Chairman. The wishes of the patient shall be considered, where feasible, in choosing a substitute Staff Member.

5) Procedural Rights

A Practitioner shall not be entitled to the procedural rights afforded by Article XII because of his or her inability to obtain Temporary Clinical Privileges or because of any termination or suspension of Temporary Clinical Privileges, unless such an event is required to be reported pursuant to the Health Care Quality Improvement Act.

D. Emergency Privileges

In the case of an emergency, any Practitioner, to the degree permitted by the Practitioner's license and regardless of Department, Staff Membership status or Clinical Privileges, shall be deemed to hold emergency Privileges, and shall be permitted and assisted, and shall not be deterred by any Staff Member, in an attempt to save the life of a patient, including the call for any consultation necessary or desirable; provided, however, that emergency Privileges are limited to Practitioners whose Clinical Privileges at the Hospital have not been previously or otherwise terminated or suspended at the time the emergency Privileges are exercised. When an emergency situation no longer exists, such Practitioner must request the Clinical Privileges necessary to continue to treat the patient. In the event such Clinical Privileges are denied or the Practitioner does not request such Clinical Privileges, the patient shall be assigned to an appropriate Staff Member. For the purpose of this Section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

E. Temporary Emergency Disaster Privileges

1) In circumstances of disaster, in which an Emergency Management Plan has been activated, the Administrator or his designee, the Chief of Staff or his designee or the Medical Director has the option, but not the requirement, of granting temporary emergency disaster privileges to licensed independent practitioners who volunteer, with or without compensation.

2) The individual granting temporary emergency disaster privileges is responsible for:

a) confirming identification by verifying: evidence of active medical licensure in the State of residence or practice; valid government issued photo identification; and at least one of the following: a current hospital picture identification, other picture identification, identification as a member of a Disaster Medical Assistance Team, and/or verification of the practitioner's identity by a current Hospital Authority employee or Medical Staff Member, if circumstances permit;

b) keeping written documentation of such information; and

c) transmitting this information to Medical Staff Services as soon as feasible.

3) Medical Staff Services will:

a) make further verification to the extent possible, as soon as possible, as described in Article V, C.(2);

b) notify the appropriate Service Chief and Department Chairman;

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c) maintain a record of the practitioner's name, address, and period of service; and

d) provide an identification badge (Volunteer Disaster Physician) for the practitioner.

4) The Service Chief and Department Chairman, or their designees, will provide supervision of the Practitioner(s) working in their Service and Department by direct and indirect observation, monitoring and/or medical record review to the extent possible during and following the disaster.

5) Temporary emergency disaster privileges will terminate when the Emergency Management Plan is declared ended.

6) Within 72 hours of arrival of the volunteer, the Hospital will determine whether the disaster privileges will be continued.

7) As soon as possible, but no later than 72 hours, primary source verification of licensure will be made by Medical Staff Services. If circumstances prevent such verification, Medical Staff Services will document the reason primary source verification could not be made, evidence of ongoing professional practice competence, and evidence of attempt to accomplish verification.

8) If primary source verification cannot be completed within 72 hours of the volunteer's arrival, it will be made as soon as possible. This requirement may be waived if the volunteer has not provided professional care, treatment or services.

F. Limited License Professionals and Allied Health Professionals

1) Applications of Limited License Professionals and Allied Health Professionals

Upon approval by the Board after formal consultation with the Medical Executive Committee, specific classes of Limited License Professionals or Allied Health Professionals shall be authorized to apply for Clinical Privileges and Clinical Functions pursuant to Article V, F.(2) and (3) below. Completed applications are reviewed by the Limited License Professionals and Allied Health Professionals Committee and forwarded to the Medical Executive Committee with its recommendation. The Medical Executive Committee may send the application back to the Limited License Professionals and Allied Health Professionals Committee or to the Professional Qualifications Committee with any concerns or questions it may have, or for clarification of any aspect of the application prior to

making its recommendation. The Medical Executive Committee may recommend that the Board: (a) approve the Clinical Privileges and/or Clinical Functions, (b) modify the Clinical Privileges and/or Clinical Functions, (c) approve the Clinical Privileges and/or Clinical Functions with conditions, or (d) deny the Clinical Privileges and/or Clinical Functions.

If the Medical Executive Committee's recommendation is adverse, as defined in Article XII of these Bylaws, to a Limited License Professional applying for Clinical Privileges, the provisions of Article XI and Article XII shall be followed prior to the Board taking final action on such adverse recommendation. Otherwise, upon receipt of the Medical Executive Committee's recommendation, the Board may forward the application back to the Medical Executive Committee with specific questions or concerns or may: (a) approve the Clinical Privileges and/or Clinical Functions, (b) modify the Clinical Privileges and/or Clinical Functions, (c) approve the Clinical Privileges and/or Clinical Functions with conditions, or (d) deny the Clinical Privileges and/or Clinical Functions.

2) Exercise of Clinical Privileges by Limited License Professionals

To the extent that classes of Limited License Professionals have been authorized by the Board to apply for Clinical Privileges pursuant to Article V, F.(1) above, the Limited License Professionals and Allied Health Professionals Committee shall prepare and submit to the Board for its approval, subject to the review of the Medical Executive Committee, a *Limited License Professionals and Allied Health Professionals Manual* (the "Manual"), detailing the required qualifications, duties and Prerogatives of Limited License Professionals seeking to exercise Clinical Privileges. All such Limited License Professionals shall exercise Clinical Privileges in accordance with the Manual as so adopted, as well as the Bylaws, Policies, Rules and Regulations of the Staff and the Hospital Authority.

3) Exercise of Clinical Functions by Limited License Professionals and Allied Health Professionals

To the extent that classes of Limited License Professionals or Allied Health Professionals have been authorized by the Board to apply for Clinical Functions, the Limited License Professionals and Allied Health Professionals Committee shall prepare as part of the Manual submitted to the Board for approval and review by the Medical Executive Committee a section detailing the required qualifications, duties and Prerogatives of those Limited License Professionals or Allied Health Professionals seeking to exercise Clinical Functions. No Limited License Professional or Allied Health Professional shall exercise Clinical Functions except as authorized by the Manual.

G. Staff Member Assistants

A Staff Member who desires to use an unlicensed or uncertified employee in an assisting capacity at the Hospital must have the employee submit an application with a completed job description which specifies exactly how the assistant will be utilized. The application must have pertinent data to identify the assistant, and include all education and experience of the assistant that are pertinent to the requested duties. The application shall include professional and character references. All responsibility and liability for the acts or omissions of the assistant are the responsibility of the Staff Member. The assistant will not: (a) assume any responsibility for care of patients, (b) sign any notes or charts, (c) sign any prescriptions, (d) write any orders, (e) dictate any histories and physicals, narrative summaries, operative reports, consults or other pertinent patient information, or (f) work independently in any capacity.

ARTICLE VI - PROCEDURES RELATING TO MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

A. Application for Medical Staff Membership, Clinical Privileges, or Both

1) Submission of Application

a) Pre-application

All Practitioners seeking initial appointment to the Medical Staff or requesting Clinical Privileges are required to submit to the Administrator or his or her designee a pre-application on the form adopted by the Medical Executive Committee and approved by the Administrator. The pre-application shall contain objective criteria to identify those Practitioners who do not satisfy the threshold eligibility criteria for the Clinical Privileges requested as established pursuant to Staff Policy MS # 13 and the threshold eligibility criteria for Staff Membership as set forth in Article III, B., as such criteria are amended from time to time (collectively the "Threshold Criteria"), including:

i) Information concerning the pre-applicant's professional qualifications, including licensure, training and whether or not the pre-applicant is Board Certified;

ii) Information concerning categories of Clinical Privileges (specialties) desired by the pre-applicant; and

iii) Information concerning the pre-applicant's current professional malpractice insurance coverage.

The Pre-Application form may also request information such as peer references which/who will not be consulted during the pre-application process, but will expedite the consideration of the individual's Application if the individual is eligible to receive an Application.

In the event there is a request for which there are no approved Clinical Privilege criteria, acting upon the recommendation of the Medical Executive Committee, as described in MS Policy #13, as amended from time to time, the Board will consider whether it will allow the Privilege. If the Board allows the Privilege, the procedures described in MS Policy #13 will be followed to develop criteria. Requests for which the Board has approved the Privilege but no specific criteria within ninety (90) days will be processed by using the general criteria of adequate education, training, clinical experience, and references demonstrating current clinical competence to perform the requested Clinical Privileges. The pre-applicant must complete and sign the pre-application form, and return the completed form to the Administrator or his or her designee. The Administrator or his or her designee or the Medical Director will determine if the application is complete and once the fully completed and executed pre-application form indicating the pre-applicant meets the Threshold Criteria has been returned, the Administrator or his or her designee shall send an application to the pre-applicant. A determination that a pre-applicant has failed to meet the Threshold Criteria and is therefore ineligible to receive an application shall not be subject to review under Article XII. Any pre-applicant who does not satisfy one or more of the Threshold Criteria may request that it be waived. The pre-applicant requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed the criterion or criteria in question. The request for a waiver shall be considered by the Professional Qualifications Committee, which shall submit its findings to the Medical Executive Committee. The Medical Executive Committee shall submit its recommendation to the Board. The Board may grant waivers in exceptional cases after considering the recommendations of the Medical Executive Committee, the specific qualifications of the pre-applicant in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case shall not set a precedent for any other individual or group of individuals. No pre-applicant is entitled to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of Staff appointment or Clinical Privileges and shall not be subject to review under Article XII of these Bylaws.

b) Form of Application and Information Required

All applications for appointment to the Staff or for granting of Clinical Privileges shall be in writing, shall be signed by the Applicant, and shall be submitted on a form adopted by the Medical Executive Committee and approved by the Administrator and provided to the Applicant by the Administrator or the Administrator's designee. In accordance with applicable law, the application shall require:

i) for Applicants seeking Medical Staff Membership, a request for appointment to a particular Staff category;

ii) a request for the specific Clinical Privileges desired by the Applicant;

iii) Information concerning the Applicant's professional qualifications, including licensure, training, documented experience in categories of treatment areas or procedures and where applicable, competence in treating age-specific patients;

iv) the names of at least three (3) Physician or other Practitioner references who can provide adequate Information on the Applicant's current professional competence and ethical character including competence to treat age-specific patients when applicable;

v) Information regarding whether the Applicant's Staff Membership status and/or Clinical Privileges have ever -- on a voluntary or involuntary basis -- been denied, revoked, suspended, diminished or not renewed at this or any other hospital or institution, whether the Applicant's Georgia Drug Enforcement Administration or other controlled substance registration has ever -- on a voluntary or involuntary basis -- been revoked, suspended or diminished, and whether his or her membership in local, state, or national medical societies, or his or her license to practice any healthcare profession in any jurisdiction, has ever -- on a voluntary or involuntary basis -- been denied, suspended or terminated;

vi) a statement that the Applicant has received and understands the Bylaws, Rules and Regulations and Policies of the Staff and the Hospital Authority, which Medical Staff Services shall make available to each Applicant upon application. By such statement, the Applicant agrees to be bound by and abide by the terms of said Bylaws, Rules and Regulations and Policies if he or she is granted Staff Membership, Clinical Privileges or both, and to be bound by the terms thereof in all matters relating to the consideration of his or her application, whether or not he or she is granted Staff Membership, Clinical Privileges or both;

vii) a statement whereby the Applicant acknowledges that he or she has been notified of the scope and extent of the authorization, confidentiality, immunity, mediation and arbitration provisions of Articles XIII and XIV;

viii) a statement whereby the Applicant agrees that if an adverse ruling is made with respect to his or her Staff Membership, Clinical Privileges or both, he or she will exhaust the administrative remedies afforded by these Bylaws before resorting to the mediation and arbitration provisions of Article XIII, and that at least thirty (30) days prior to the filing or initiation of any mediation or arbitration action against the Staff, any Staff Member,

or the Hospital Authority, arising out of or in connection with the application process, the Applicant shall notify the Administrator or his or her designee of his or her intended action setting forth therein the basis for such action and the specific allegations and contentions;

ix) a statement of his or her willingness to appear for an interview in regard to his or her application;

x) a statement disclosing any present mental or physical conditions that may pose a threat to the health or safety of others that cannot be eliminated by reasonable accommodation;

xi) a statement that he or she has under adequate control such that patient care is not likely to be adversely affected, any significant physical or behavioral impairment or any difficulty in communicating orally or in writing in the English language; and

xii) a statement whereby the Applicant certifies that he or she maintains professional malpractice insurance coverage in at least such amount as may be required by applicable provisions of these Bylaws, the Hospital Authority Bylaws or other Staff or Hospital Authority Rules and Regulations or Policies, and which specifies the amount of said coverage, and the name and address of the malpractice insurer. The application shall further require complete disclosure concerning any malpractice claims against the Applicant, any amount paid by or on behalf of the Applicant upon final judgment or settlement of such claim, and the basis of the claim if such payment was made. The application shall contain a statement whereby the Applicant agrees to notify the Administrator or Medical Staff Services promptly of any changes in said professional malpractice insurance, any claims against said professional malpractice insurance which result in payment to the claimant, and any adverse final judgments or settlements in any professional liability action.

c) Effect of Application

By submitting an application, reapplication or reappointment form, the Applicant or Practitioner:

i) authorizes the Staff and Hospital Authority to contact other hospitals with which the Applicant has been associated and others who may have information bearing on his or her licensure, competence, character and ethical qualifications, including without limitation the National Practitioner Data Bank as established by the Health Care Quality Improvement Act;

ii) agrees to attest to his or her physical, emotional, and mental status;

iii) consents to a psychiatric or other medical evaluation and a chemical test or test of blood, breath, urine and other bodily substances for the purpose of determining his or her ability to render or participate in patient care, where such tests or evaluation are relevant to the Applicant's ability to exercise the Clinical Privileges requested and are requested at any time during the application process by the Chairman of the Professional Qualifications Committee or the Chairman of the Department in which the Applicant is seeking Clinical Privileges, or the Chief of Staff, or if such tests or evaluation are requested by the Medical Staff Support Committee after such time as Staff Membership, Clinical Privileges or both are granted;

iv) consents to the Staff and the Hospital Authority inspecting all records and documents that may be material to an evaluation of his or her professional qualifications, current professional competence to carry out the Clinical Privileges he or she requests, and in the case of an Applicant applying for Staff Membership, his or her moral and ethical qualifications for Staff Membership;

v) releases from any liability all individuals and organizations who provide Information in good faith and without malice concerning the Applicant's competence, ethics, character, and other qualifications for Staff Membership appointment, Clinical Privileges or both, including otherwise privileged or confidential Information;

vi) acknowledges that any actions or recommendations of any Committee or the Board with respect to the evaluation of the medical and health services provided by the Applicant or Practitioner, or the evaluation of the qualifications and/or professional competency of an Applicant or Practitioner are done so as a medical review Committee and are part of the professional peer review process; and

vii) pledges to provide for continuous care for his or her patients if granted Clinical Privileges.

d) Burden of Providing Information

i) The Applicant shall have the burden of producing Information deemed adequate by the Board for a proper evaluation of his or her current competence, character, ethics, ability to perform the Clinical Privileges requested and other qualifications, and for resolving any doubts about such qualifications. Said application shall not be considered complete for purposes of

processing until such satisfactory Information is provided by the Applicant and verified by the Administrator or the Medical Director.

ii) Applicants seeking appointment have the burden of providing evidence that all the statements made and Information given on the application are accurate.

iii) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all Information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying Information at any time. Any application that continues to be incomplete thirty (30) days after the Applicant has been notified of the additional Information required shall be deemed to be withdrawn.

iv) The Applicant seeking appointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

e) Completed Application

The completed application and a non-refundable application fee of Five Hundred and 00/100 Dollars ($500.00) shall be made payable to the Hospital Authority and shall be submitted to the Administrator. (Note: Emergency Department Residents are exempt from paying the application fee.) All such fees shall be designated and used for continuing medical education for the Medical Staff or such other Medical Staff related expenses as approved from time to time by the Medical Executive Committee. The application shall not be considered complete until: all blanks on the application form are filled in and necessary additional explanations provided; all supporting documentation has been supplied; written verification of the Applicant's current licensure, specific relevant training and current competence (from the primary source whenever feasible, or from a verification organization) is obtained; and the Administrator or the Medical Director, with the full cooperation of the Applicant, has received necessary references and materials required to be submitted under this Article VI, A.(1). Any determination made by the Administrator or the Medical Director that the application is complete shall not foreclose a subsequent decision that the application has become incomplete. Once the completed application is received, the Administrator or the Medical Director shall begin the appointment process by immediately transmitting the application and all supporting materials (collectively, the "Application Materials") to each Section Chief, Chief of Service and Department Chairman in which the Applicant seeks Clinical Privileges and by contacting the National Practitioner Data Bank to obtain any relevant information concerning the Applicant. An application shall

become incomplete if the need arises for new, additional or clarifying Information at any time. In such event, the Administrator shall promptly return the application to the Applicant, together with a notice specifying the Information or documentation found to be incomplete and advising the Applicant that the application shall not be considered complete, so as to invoke the time limits of Article VI,A.(6)(a) hereof, until the Applicant has furnished all requested Information. Any application that continues to be incomplete thirty (30) days after the Applicant has been notified of the additional Information required shall be deemed to be withdrawn.

2) Additional Application Materials

As soon as possible after forwarding the Application Materials to each Section Chief, Chief of Service and Department Chairman in which the Applicant seeks Clinical Privileges, the Administrator or the Medical Director shall forward any relevant Information received from the National Practitioner Data Bank to each Section Chief, Chief of Service and Department Chairman in which the Applicant seeks Clinical Privileges. In the event any such person has already submitted a written report to the Professional Qualifications Committee in accordance with Article VI, A.(3) below, that person shall immediately forward all information received from the National Practitioner Data Bank to such Committee, along with any appropriate written modification to the written report previously submitted to such Committee.

3) Department Action

Upon receipt of the Application Materials, each applicable Section Chief, Chief of Service and Department Chairman in which the Applicant requests Clinical Privileges shall examine evidence of the licensure, character, current professional competence, qualifications, and ethical standing of the Applicant and shall consider whether the Applicant has established and meets all of the necessary requirements for the Clinical Privileges requested by the Applicant, specific to the ages and populations served when applicable and, in the case of an Applicant applying for Staff Membership, for the particular category of Staff Membership sought. Within thirty (30) days of the receipt of the Application Materials, each Section Chief, Chief of Service and Department Chairman shall make a written report to the Professional Qualifications Committee, stating whether the Applicant is qualified pursuant to the Bylaws for the Staff Membership and/or Clinical Privileges sought and any concerns regarding the application. The reasons for conclusions contained in the report shall be stated and supported by reference to the Application Materials and all other documentation considered by each Section Chief, Chief of Service and the Department Chairman, all of which shall be transmitted with the report.

4) Professional Qualifications Committee Action

Upon receipt of the Application Materials and the written reports from each Section Chief, Chief of Service and Department Chairman, the Professional Qualifications Committee shall examine the evidence of the licensure, character,

professional competence (including current competence to treat age-specific patients and populations when applicable), qualifications, health status, and ethical standing of the Applicant and shall determine, through Information contained in references given to the Professional Qualifications Committee, including the appraisal from the Section(s), Service(s) and Department(s) in which Clinical Privileges are sought, whether the Applicant has established and meets all of the necessary qualifications for any requested category of Staff Membership or any requested Clinical Privileges.

5) Medical Executive Committee Action

Upon receipt of the Application Materials, written report of each Section Chief, Chief of Service and Department Chairman and the recommendation of the Professional Qualifications Committee, the Medical Executive Committee shall examine the evidence of the licensure, character, current professional competence (specific to age and populations served when applicable), qualifications, and ethical standing of the Applicant and shall determine, through Information contained in references given to the Medical Executive Committee, including the reports from the Section(s), Service(s) and Department(s) in which Clinical Privileges are sought and the recommendation of the Professional Qualifications Committee whether the Applicant has established and meets all of the necessary qualifications for any requested category of Staff Membership or any requested Clinical Privileges. The Medical Executive Committee may send the application back to the Professional Qualifications Committee with any concerns or questions it may have, or for clarification of any aspect of the application prior to making its recommendation. Prior to the last scheduled monthly meeting of the Board falling within the time limits set forth in Article VI, A.(6)(a) below, the Medical Executive Committee may recommend that the Board: (i) approve the appointment and Clinical Privileges, (ii) approve the appointment, but modify the Clinical Privileges, (iii) approve the appointment with conditions, or (iv) deny the appointment. Together with its report, the Medical Executive Committee shall forward all documentation considered in arriving at its recommendation as provided in Article VI, A.(6) below. Any minority views may also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

6) Board Action

a) Time Limitation

Whenever an Applicant shall make application for Staff Membership, Clinical Privileges or both, the Board must take final action thereon within sixty (60) days of the Board's receipt of the completed application and recommendation from the Medical Executive Committee.

b) Action on a Favorable Recommendation

When the recommendation of the Medical Executive Committee is favorable to the Applicant, the Medical Executive Committee shall

promptly forward the Application Materials, a written recommendation and all supporting documents, to the Administrator, for the Board's consideration at its next scheduled monthly meeting. The Board shall act on the matter at such meeting or no later than the next consecutive scheduled monthly meeting held after such meeting. The Board may either: (i) approve the appointment and Clinical Privileges, (ii) approve the appointment, but modify the Clinical Privileges, (iii) approve the appointment with conditions, (iv) deny appointment, or (v) return the application to the Medical Executive Committee for clarification or further investigation of any aspect of the application that is unclear or of concern to the Board.

Whenever a decision is made by the Board to grant Staff Membership, Clinical Privileges or both to an Applicant, the Administrator or his or her designee shall notify the Applicant promptly in writing of the appointment, including any Staff category to which he or she is appointed, the Department and Service to which he or she is assigned, the Clinical Privileges he or she may exercise and any special conditions attached to the appointment. In cases where Clinical Privileges bridge more than one Department or Service, the Applicant will be assigned to one Department and Service, but the exercise of Clinical Privileges will be governed by policies of and reviewed by all Departments and Services with jurisdiction over such Clinical Privileges.

Whenever the Board's decision is contrary to a favorable recommendation of the Medical Executive Committee, notice to the Applicant shall be effectuated pursuant to Article VI, A.(6)(c) below, and the hearing and appeal mechanism outlined in Article XII shall be followed.

c) Action on an Adverse Recommendation

When the recommendation of the Medical Executive Committee is adverse to the Applicant, the Medical Executive Committee shall promptly forward the Application Materials, a written recommendation and all supporting documents to the Administrator. The Administrator shall notify the Applicant within ten (10) days of such action by registered mail, certified mail, or by personal service, stating the action taken and the reasons therefore, and advising the Applicant of his or her right to a hearing or an appellate review pursuant to Article XII. The written notice shall also specify that the Applicant shall have:

i) thirty (30) days following the date of receipt of such notice within which to request a hearing or appellate review;

ii) state that failure to request a hearing or an appellate review within the specified time period shall constitute a waiver of his or her right to the same;

iii) state that upon receipt of his or her request, he or she will be notified of the date, time and place for the hearing or appellate review and the grounds upon which the adverse action is based;

iv) advise him or her of his or her right to review the hearing record and report, if any, and to submit a written statement in his or her behalf as part of the appellate procedure; and

v) advise him or her of his or her right to representation by counsel at the hearing or appellate review.

When the recommendation of the Medical Executive Committee is adverse to the Applicant, the hearing and appeal mechanism outlined in Article XII shall be followed before the Board makes a final decision on the matter. The failure of an Applicant to request a hearing pursuant to the terms of Article XII shall be deemed a waiver of his or her right to such hearing and any appellate review to which he or she might otherwise have been entitled.

A decision by the Board to deny Staff Membership or a particular Clinical Privilege either on the basis of the Hospital Authority's present inability, as supported by documented evidence, to provide adequate facilities or supportive services for the Applicant and his or her patients shall not be considered adverse in nature and shall not entitle the Applicant to the procedural rights as provided in Article XII.

7) Reapplication After Denial

The Medical Executive Committee shall submit with its adverse recommendation on an Applicant's request for Staff Membership, Clinical Privileges or both, a recommendation as to any time limitations to be placed upon the Applicant's eligibility to reapply for admission to the Staff or for Clinical Privileges. The recommended period of ineligibility to reapply shall be based upon that minimum period of time the Medical Executive Committee considers necessary for the Applicant to remedy the basis for the adverse recommendation, and shall in no event exceed two (2) years. The period of time of ineligibility, if any, shall be determined by the Board and designated in the notice to the Applicant of the final decision. Any reapplication shall be made on an application form and processed as an initial application, and the Applicant shall submit such additional Information as the Staff or the Board may require and demonstrate that the basis for the earlier adverse action no longer exists.

8) Initial Appointment to Medical Staff, Grant of Clinical Privileges or Both

All initial appointments to the Active Medical Staff shall be provisional status for a period of two (2) years. All advancements from provisional status to regular status shall be for no more than a two (2) year period from the advancement until the member is reappointed in accordance with Article VI, D.(1) below or his or

her appointment expires. In granting Clinical Privileges to an Applicant, the Board shall delineate specifically the Clinical Privileges which the Applicant may exercise, with the right to exercise such Clinical Privileges continuing for the period until the Practitioner's Clinical Privileges are modified, renewed or expire. Separate records shall be maintained by Medical Staff Services for each Applicant, whether or not the Applicant is appointed to the Staff or granted Clinical Privileges.

Newly appointed Medical Staff Members will be given one hundred twenty (120) days from the date of appointment to begin exercising the Clinical Privileges granted to such Member at the Hospital. Failure to do so will constitute a voluntary relinquishment by the Staff Member of his or her Clinical Privileges and a voluntary resignation from Staff Membership, unless the Practitioner requests a waiver of this requirement or requests a change in the category to Affiliate status, provided Practitioner satisfies the qualifications for the Affiliate Staff category. The Medical Executive Committee shall consider the request and submit its recommendation to the Board. The granting of a waiver by the Board, in a particular case shall not set a precedent for any other individual or group of individuals. Neither the determination not to grant a waiver, nor the voluntary relinquishment and resignation shall be subject to review under Article XII of these Bylaws.

B. Application for Additional Clinical Privileges

Applications for additional Clinical Privileges by Staff Members or others must be in writing. Such applications shall be processed in the same manner as applications for initial appointment outlined in Article VI, A. above, and shall require the same documentation.

C. Application for Clinical Privileges Not Previously Approved

1) Reference to Joint Conference Committee

Whenever an application by a Practitioner for original or additional Clinical Privileges requests Clinical Privileges which would constitute the performance or application of a technique, operation, medication, procedure or therapy which has not previously been approved by the Staff and Board or which has not prior to that time been performed at the Hospital with the approval of the Staff and Board, the Professional Qualifications Committee will follow the procedures contained in Staff Policy MS #13, as such policy is amended from time to time. After the Professional Qualifications Committee and the relevant Department have reported to the Medical Executive Committee pursuant to Article VI, A.(3) and A.(4) above, if the Medical Executive Committee is unable to make a recommendation in response to the application, the Medical Executive Committee shall refer the matter to the Joint Conference Committee, described in Article X, J., by the calling by the Chairman of the Medical Executive Committee of a meeting of the Joint Conference Committee. The application of the Practitioner and all relevant documents, references and reports relevant thereto shall be forwarded to the Joint Conference Committee.

2) Consideration of Other Clinical Privileges

Pending the outcome of the investigation by the Joint Conference Committee, the application for Staff Membership, Clinical Privileges or both may be recommended to be approved or disapproved by the Staff and granted or rejected by the Board in accordance with the procedures described in Article VI, A. above, excluding from said process the requested Clinical Privilege to perform the particular practice being considered herein.

3) Joint Conference Committee Action

The Joint Conference Committee shall meet within fifteen (15) days of the calling of a meeting, and may request additional Information from the Applicant concerning the questioned practice. The Joint Conference Committee shall consider criteria such as: (i) the Hospital Authority's present ability to provide adequate facilities and supportive services for the Applicant and for the safety of the Applicant's patients; (ii) whether the procedure is consistent with the Hospital Authority's plan of development; (iii) whether the procedure is consistent with the present mix of patient care services; (iv) whether other similar hospitals in the same geographic area are performing the procedure, and if not, the reasons therefor; (v) whether other similar hospitals in Georgia are presently performing the procedure, and if not, the reasons therefore; (vi) whether the procedure would be more appropriately performed in a different type of hospital; (vii) whether or not the safety of all patients in the Hospital can be assured; (viii) sound medical judgment; and (ix) other criteria determined relevant and appropriate by the Committee. After considering the Information and data before it, the Joint Conference Committee shall make its report and recommendation to both the Medical Executive Committee and the Board. The application and all relevant documents, reports and Information shall be returned to the Medical Executive Committee along with the Joint Conference Committee's advisory recommendation. The Medical Executive Committee shall then continue with the appointment process as outlined in this Article VI. The affected Applicant's right to appellate review provided in Article XII shall not become effective by an adverse recommendation by the Joint Conference Committee, but only by a subsequent adverse recommendation by the Medical Executive Committee or decision by the Board as provided in Article VI, A.(6).

D. Reappointment to Staff or Renewal of Clinical Privileges

1) Schedule for Reappointment

a) Reappointments to the Staff and renewals of Clinical Privileges are processed twice each calendar year. All reappointments to the Staff or renewals of Clinical Privileges shall be on the Applicant's birth month two (2) years after the prior appointment provided such reappointment shall not exceed more than two (2) years

following the prior appointment, with Staff Membership and Clinical Privileges expiring at midnight of the night prior to the second anniversary after the previous appointment for Staff Members or other Practitioners.[3] Each Staff Member shall be reviewed for reappointment and renewal of Clinical Privileges every two (2) years so that Board action on such reappointment or renewal may be taken prior to the applicable date listed above. Each Practitioner exercising Clinical Privileges who is not a Staff Member shall be reviewed for the renewal of Clinical Privileges every two (2) years so that Board action on such renewal may be taken prior to the applicable date listed above. Reappointment is never to exceed two (2) years.

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b) All applications for reappointment to the Staff or for granting of Clinical Privileges shall be in writing, shall be signed by the Applicant, and shall be submitted on a form adopted by the Medical Executive Committee and approved by the Administrator and provided to the Applicant by the Administrator or the Administrator's designee approximately four (4) months prior to the expiration of their current appointment term. A completed reappointment application must be returned to Medical Staff Services within thirty (30) days.

c) Failure to submit a complete application in a timely manner shall result in automatic expiration of Staff Membership and Clinical Privileges at the end of the then-current term of appointment and the Practitioner may not exercise Clinical Privileges until an application is processed.

d) If an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the Applicant's appointment and Clinical Privileges shall expire at the end of the then-current term of appointment. Temporary Clinical Privileges may be granted under appropriate circumstances as set forth in Article V, C. of these Bylaws. Subsequent Board action may be to grant reappointment and renewal of Clinical Privileges.

e) In the event the Applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two (2) years may be granted pending the completion of that process.

2) Eligibility for Reappointment

To be eligible to apply for reappointment and renewal of Clinical Privileges, an Applicant must have, during the previous appointment term:

[3] Please note, during the initial transition to the reappointment falling on the Applicant's birth month, the reappointment process may occur prior to the expiration of a two year reappointment.

a) completed all medical records by the time of submission of his or her reappointment form;

b) completed all continuing medical education requirements;

c) satisfied all Medical Staff responsibilities;

d) continued to meet all qualifications and the Threshold Criteria for appointment to the Staff and Clinical Privileges requested; and

e) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the Clinical Privileges requested. Any Applicant seeking reappointment who has minimal activity at the Hospital must submit such Information as may be requested (such as a copy of his or her confidential quality profile from other hospital(s) with which he or she is affiliated, clinical Information from the Applicant's private office practice, and/or a quality profile from a managed care organization), before the application will be considered complete and processed further.

3) Application for Reappointment

a) The Administrator or his or her designee or the Medical Director will determine if the application is complete and whether the Applicant satisfies the Threshold Criteria for Membership as set forth in Article III, B. and the threshold criteria for the Clinical Privileges requested, as established pursuant to Staff Policy MS #13, as such criteria are amended from time to time (collectively the "Threshold Criteria"). If the Applicant meets such Threshold Criteria, the Administrator or his or her designee, or the Medical Director shall within ten (10) business days of receipt and verification of completeness forward the Application Form for Reappointment to the Professional Qualifications Committee.

The determination that the Applicant fails to meet the Threshold Criteria and is therefore ineligible for reappointment shall not be subject to review under Article XII. An Applicant who does not satisfy one or more of the Threshold Criteria may request that it be waived. The Applicant requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to or exceed the criterion or criteria in question. The request for a waiver shall be considered by the Professional Qualifications Committee, which shall submit its findings to the Medical Executive Committee. The Medical Executive Committee shall submit its recommendations to the Board. The Board may grant waivers in exceptional cases after considering the recommendations of the Medical Executive Committee, the specific qualifications of the Applicant in question and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case shall not set a precedent for any other individual or group of individuals. No Applicant is entitled to a hearing if the Board determines not to grant a waiver. A determination

that an Applicant is not entitled to a waiver is not a "denial" of appointment to the Staff or Clinical Privileges and shall not be subject to review under Article XII.

b) The Application Form for Reappointment shall contain Information necessary to maintain a current file on the Applicant's healthcare-related activities other than as a Staff Member. The Application Form for Reappointment shall include, without limitation, Information about the following:

i) reasonable evidence of current physical and mental health status, as the same may be requested by the Professional Qualifications Committee or the Medical Executive Committee;

ii) the name and address of any other healthcare institution or hospital where the Practitioner provided clinical services during the preceding period, and the specific Clinical Privileges which were authorized or exercised by the Practitioner at said institution or hospital;

iii) sanctions of any kind -- on a voluntary or involuntary basis -- imposed by any other healthcare institution, hospital, the Georgia or Federal Drug Enforcement Administration, or licensing authority;

iv) complete disclosure concerning the status of professional malpractice insurance coverage, claims, suits, and settlements;

v) evidence of continuing medical education, as required by the appropriate state licensing authority; and

vi) current information regarding the Practitioner's continuing training, education and experience, including evidence of completion of continuing medical education required by state or federal law or regulation.

c) Burden of Providing Information

i) Applicants seeking reappointment have the burden of producing Information deemed adequate by the Board for a proper evaluation of current competence, character, ethics, ability to perform the Clinical Privileges requested and other qualifications and for resolving any doubts.

ii) Applicants seeking reappointment have the burden of providing evidence that all the statements made and Information given on the application are accurate.

iii) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all Information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional or clarifying Information at any time. Any application that continues to be incomplete thirty (30) days after the Applicant has been notified of the additional Information required shall be deemed to be withdrawn.

iv) An Applicant seeking reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

4) Bases of Recommendation

Each recommendation concerning the reappointment and renewal of Clinical Privileges shall be based upon:

a) the Practitioner's current professional competence in the treatment of patients, specific as to competence in treating age-specific patients, when applicable;

b) the Practitioner's continued ability to perform the Clinical Privileges requested;

c) the Practitioner's ethics and conduct;

d) the Practitioner's attendance at required Staff and Department meetings and participation in required Staff and Department affairs and Committees;

e) the Practitioner's compliance with the Bylaws, Rules and Regulations, and Policies of the Staff and the Hospital Authority;

f) the Practitioner's maintenance of timely, accurate, and complete medical records;

g) the Practitioner's patterns of care, as demonstrated by reviews conducted by the appropriate Committees of the Staff and comparisons of Practitioner-specific data to aggregate data if such data is available for that Practitioner when these measurements are appropriate for comparative purposes in evaluating continued ability to provide quality care, treatment and services for the Clinical Privileges requested;

h) the Practitioner's behavior and cooperation with other Staff Members and Hospital personnel; and

i) continuing education as recommended by each Department in which the Staff Member seeks reappointment or renewal.

A written record of matters considered in each Practitioner's periodic reappointment or renewal appraisal shall be made a part of the Practitioner's Medical Staff file. Any actions or recommendations of any Committee or the Board with respect to the evaluation of the Practitioner's qualifications, professional competence and performance of medical and health services of the Practitioner are done so as a medical review committee and are part of the professional peer review process.

5) Professional Qualifications Committee Action

Upon receipt of the Application Form for Reappointment of any Practitioner, Medical Staff Services, as the agent of the Medical Executive Committee, will contact the National Practitioner Data Bank to obtain relevant information concerning the Practitioner. The Professional Qualifications Committee shall review all pertinent information available on each Practitioner scheduled for periodic appraisal prior to the Board meeting scheduled for the month in which such Practitioner's appointment will expire. The Professional Qualifications Committee shall seek input regarding reappointment or renewal of Clinical Privileges from the Chairman of the Clinical Department(s) to which the Practitioner is assigned, and the Chief(s) of Service(s). The Professional Qualifications Committee may also seek input regarding reappointment or renewal of Clinical Privileges from individual Practitioners. In the event reliable information is obtained that a Practitioner has developed a physical or mental disability that may limit his or her ability to exercise the Clinical Privileges previously granted, the Professional Qualifications Committee, in conjunction with the Medical Staff Support Committee, shall fully appraise the health status of any such Practitioner during the reappointment process, or shall recommend to the Medical Executive Committee that such be done on an emergency basis, if required, (see Precautionary Suspension: Article XI, c. if required. The Professional Qualifications Committee shall require the Practitioner to submit evidence to the Committee of his or her current physical and/or mental status relevant to his or her ability to exercise the Clinical Privileges granted to the Practitioner, as determined by a Physician acceptable to the Committee. The Committee shall forward its written recommendations to the Medical Executive Committee. When the denial of reappointment, a change in Clinical Privileges, or a reduction in Clinical Privileges is recommended, the reasons for such recommendations shall be stated and documented.

6) Medical Executive Committee Action

a) Upon receipt of all pertinent information from the Professional Qualifications Committee, including the Application Form for Reappointment and any information obtained from the National Practitioner Data Bank, the Medical Executive Committee shall review the information along with the recommendation of the Professional Qualifications Committee for the purpose of determining its

recommendation for reappointment to the Staff and for granting of Clinical Privileges for the ensuing period. The Medical Executive Committee may recommend that the Board: (i) approve the appointment and Clinical Privileges, (ii) approve the appointment, but modify the Clinical Privileges, (iii) approve the appointment with conditions, or (iv) deny the appointment. Together with its report, the Medical Executive Committee shall forward all documentation considered in arriving at its recommendation as provided below. Any minority views may also be reduced to writing, supported by reasons and references, and transmitted with the majority report. The Medical Executive Committee may send the application back to the Professional Qualifications Committee with any concerns or questions it may have, or for clarification of any aspect of the application prior to making its recommendation.

b) If the Medical Executive Committee's recommendation is that the Applicant be reappointed to the Staff, and that all Clinical Privileges requested be granted, the Medical Executive Committee shall promptly forward it, together with all supporting documents, to the Board for consideration at its next scheduled monthly meeting.

c) When the recommendation of the Medical Executive Committee is adverse to the Applicant, the Medical Executive Committee shall promptly forward its written recommendation together with all supporting documents to the Administrator. The Administrator shall notify the Applicant within ten (10) days of such action by registered mail, certified mail, or by personal service, stating the action taken and the reasons therefore, and advising the Applicant of his or her right to a hearing or an appellate review pursuant to Article XII. The written notice shall also:

i) specify that the Applicant shall have thirty (30) days following the date of receipt of such notice within which to request a hearing or appellate review;

ii) state that failure to request a hearing or an appellate review within the specified time period shall constitute a waiver of his or her right to the same;

iii) state that upon receipt of his or her request, he or she will be notified of the date, time and place for the hearing or appellate review and the grounds upon which the adverse action is based;

iv) advise him or her of his or her right to have a record made of the proceedings, copies of which may be obtained by the Applicant upon payment of reasonable charges;

v) advise him or her of his or her right to representation by a lawyer or other person of his or her choice;

vi) advise him or her of his or her right to present evidence determined to be relevant by the Presiding Officer regardless of its admissibility in a court of law;

vii) advise him or her of his or her right to submit a written statement on his or her behalf at the close of the hearing; and

viii) include a copy of Article XII.

When the recommendation of the Medical Executive Committee is adverse to the Applicant, the hearing and appeal mechanism outlined in Article XII shall be followed before the Board makes a final decision on the matter. The failure of an Applicant to request a hearing pursuant to the terms of Article XII shall be deemed a waiver of his or her right to such hearing and any appellate review to which he or she might otherwise have been entitled.

7) Board Action

a) If the recommendation of the Medical Executive Committee is favorable to the Applicant, the Board may either: (i) approve the reappointment and Clinical Privileges, (ii) approve the reappointment, but modify the Clinical Privileges, (iii) approve the reappointment with conditions, (iv) deny reappointment, or (v) return the application to the Medical Executive Committee for clarification or further investigation of any aspect of the application that is unclear or of concern to the Board.

b) If the Board determines to accept the Medical Executive Committee's recommendation to approve the Applicant's reappointment and to grant the Clinical Privileges requested, the Board's decision shall be sent to the Administrator, who notifies the Applicant of the Board's action.

c) If the Board approves the reappointment but denies some of the Clinical Privileges requested or denies a change in Staff category, notice to the Applicant shall be effectuated pursuant to Article VI, A.(6)(c), and the hearing and appeal mechanism outlined in Article XII shall be followed.

d) A decision by the Board to deny Staff Membership or a particular Clinical Privilege either on the basis of the Hospital Authority's present inability, as supported by documented evidence, to provide adequate facilities or supportive services for the Applicant and his or her patients shall not be considered adverse in nature and shall not entitle the Applicant to the procedural rights as provided in Article XII. If the Board determines to reject the Medical Executive Committee's favorable recommendation and to deny reappointment, notice to the Applicant shall be effectuated pursuant to Article VI, A.(6)(c), and the hearing and appeal mechanism outlined in Article XII shall be followed.

8) Conditional Reappointment

a) The Professional Qualifications Committee or the Medical Executive Committee may recommend and the Board may, with or without the Medical Executive Committee's recommendation, grant reappointment and renewed Clinical Privileges subject to the Applicant's compliance with specific conditions. These conditions may relate to behavior or to clinical issues. The imposition of these conditions does not entitle an Applicant to request the procedural rights set forth in Article XII, unless the conditions fall within the scope of the recommendations defined as "adverse" pursuant to Article XII.

b) In addition, reappointments may be granted for periods of less than two (2) years in order to emphasize the seriousness of the matter and to permit closer monitoring of an Applicant's compliance with any conditions. A recommendation for, or the Board's granting of, reappointment for a period of less than two (2) years does not, in and of itself, entitle an Applicant to the procedural rights set forth in Article XII.

9) Failure to File for Reappointment

Failure by a Practitioner, without good cause, to return the Application Form for Reappointment in a timely manner pursuant to Article VI, D.(1) of these Bylaws shall result in automatic expiration of such Practitioner's Staff Membership and Clinical Privileges at the expiration of the Practitioner's current term.

10) Reapplication

The Medical Executive Committee shall submit with its adverse recommendation concerning the reappointment or renewal of Staff Membership, Clinical Privileges or both, a recommendation as to any time limitations to be placed upon the Practitioner's eligibility to reapply for admission to the Staff or for Clinical Privileges or both (as appropriate). The recommended period of ineligibility to reapply shall be based upon that minimum period of time the Medical Executive Committee considers necessary for the Practitioner to remedy the basis for the adverse recommendation, and shall in no event exceed two (2) years. The period of time of ineligibility to reapply, if any, shall be determined by the Board and shall be designated in the notice to the Practitioner of the final decision. Any reapplication shall be processed as an initial application, and the Practitioner shall submit such additional information as the Staff or the Board may require and demonstrate that the basis for the earlier adverse action no longer exists.

E. Period of Evaluation

1) General Provisions

Except as specifically waived by the Board, upon consultation with and agreement by the Medical Executive Committee, all initial appointees to the

Active Staff and all Practitioners granted original or additional Clinical Privileges shall be subject to a period of evaluation and review. Each appointee or recipient of new Clinical Privileges including, without limitation, temporary privileges, shall be assigned to a Department and a Service where performance of an appropriate number of cases shall be evaluated and reviewed pursuant to Medical Staff Policy, MS # 1, *Medical Staff Review of Practitioners' Performance*, as amended from time to time pursuant to these Bylaws to determine suitability to continue to exercise the Clinical Privileges granted in that Department. The exercise of Clinical Privileges in any other Department shall also be subject to evaluation by that Department's Chairman or his or her designee. Appropriate records documenting such evaluations shall be furnished to the Professional Qualifications Committee. The Practitioner shall remain subject to evaluation until the Professional Qualifications Committee has furnished the Medical Executive Committee with:

a) A certification signed by the Chairman of the Department to which the Practitioner is assigned describing the types and numbers of cases observed and the evaluation of the Practitioner's performance, stating that the Practitioner appears to meet all of the qualifications for exercising Clinical Privileges in that Department, the Practitioner has satisfactorily demonstrated, through the applicable evaluation process, his or her ability for continued exercise of Clinical Privileges, and, in the case of Staff Members, stating that the Staff Member has discharged all of the responsibilities of Staff Membership and has not exceeded or abused the Prerogatives of the category to which the appointment was made. The certification shall specifically state sufficient treatment of patients has occurred to properly evaluate the Clinical Privileges being exercised.

b) A certification signed by the Chairman of the other Department(s) in which the Practitioner may exercise Clinical Privileges, describing the types and number of cases observed and the evaluation of the Practitioner's performance and stating that the Practitioner has satisfactorily demonstrated the ability to exercise the Clinical Privileges initially granted in such Department(s).

2) Failure to Obtain Certification

a) If an initial appointee to the Staff or Practitioner exercising new Clinical Privileges fails within the time of provisional status to furnish the certifications required, those specific Clinical Privileges shall automatically terminate unless the Board extends the term of provisional status pursuant to Article IV, B. of these Bylaws, and the Practitioner shall be entitled to a hearing upon request, pursuant to Article XII, unless the failure to obtain such certificates is not adverse as defined by Article XII.

b) The failure to obtain certification for any specific Clinical Privilege shall not, of itself, preclude advancement from provisional status to regular status in the Staff category of any Staff Member. If such advancement is granted absent satisfactory completion of a required

period of evaluation, continued evaluation on any unapproved procedure shall continue for the specified time period.

F. Consultation

There may be attached to any grant of Clinical Privileges, in addition to requirements for consultation in specified circumstances provided for in the Bylaws, the Rules and Regulations or Policies of the Staff, any of the Departments or the Hospital Authority, special requirements for consultation as a condition to the exercise of particular Clinical Privileges.

G. Leave of Absence

1) Leave Status

a) At the discretion of the Medical Executive Committee, a Staff Member may obtain a voluntary leave of absence from the Staff upon submitting a written request to the Medical Executive Committee stating: (i) the approximate period of leave desired, which may not exceed one (1) year; and (ii) the reasons for the request. In the event of an emergency, the Medical Executive Committee, the Chief of Staff or his or her designee, or the Chief Medical Officer of his or her designee may grant a voluntary leave of absence. Voluntary leaves of absences shall be granted only for health reasons, military service, or furthering education, family emergency at the discretion of the MEC, Chief Medical officer or Chief of Staff. During the period of any permitted voluntary leave, the Staff Member shall not exercise Clinical Privileges at the Hospital, and Staff Membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Executive Committee. A Staff Member may submit a written request to the Medical Executive Committee to renew the voluntary leave of absence, provided the total period of leave does not exceed one (1) year.

b) At the discretion of the Medical Executive Committee, a Staff Member may obtain a voluntary leave of absence from the Staff of greater than one (1) year upon submitting a written request to the Medical Executive Committee stating: (i) the approximate period of leave desired; and (ii) the reasons for the request. During the period of any voluntary leave of greater than one (1) year, the Staff Member shall not exercise Clinical Privileges at the Hospital. Staff Membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Executive Committee.

c) A thirty (30) day notice is required prior to granting a voluntary leave of absence except in emergency situations.

2) Termination of Leave

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Staff Member may request reinstatement of Clinical Privileges by submitting a written notice to that effect to the Medical Executive Committee. The Staff Member shall submit a summary of relevant activities during the leave if the Medical Executive Committee so requests. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the Staff Member's Clinical Privileges, and the procedure provided for initial appointment and granting of initial Clinical Privileges shall be followed. Any Staff Member on leave for greater than one (1) year shall be required to be on provisional status in accordance with Article IV, B., provided, however, such status shall only remain provisional for one (1) year unless extended pursuant to Article IV, B.

3) Reappointment During Leave of Absence

In the event that the term of a Practitioner's Medical Staff Membership and/or Clinical Privileges will expire during the Practitioner's requested Leave of Absence, the Practitioner may apply for reappointment prior to the beginning of the Leave of Absence or the Practitioner may apply during the term of his or her Leave of Absence. However, if the Practitioner fails to submit a complete application for reappointment and/or for Clinical Privileges at least within the time frame set forth in Article VI, D., the Practitioner's Medical Staff Membership and Clinical Privileges automatically expire as of the last day of his or her then-current term of appointment. Thereafter, if the Practitioner seeks appointment to the Medical Staff or requests Clinical Privileges, the Practitioner is subject to the initial application process for Medical Staff Membership and/or Clinical Privileges pursuant to Article VI, A.

4) Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Staff and voluntary relinquishment of Clinical Privileges, effective as of the expiration of the voluntary leave period approved by the Medical Executive Committee. A request for Staff Membership subsequently received from such a Practitioner shall be submitted and processed in the manner specified for applications for initial appointments.

H. Exclusive Provider Arrangements

Any decision to execute, renew, modify or terminate any exclusive provider arrangement with the Hospital Authority is subject to the approval of the Board. In connection with the Board's decision to execute, renew, modify or terminate any exclusive provider arrangement with the Hospital Authority in any Department or Service, the Board shall seek the comments of the Medical Executive Committee regarding the effect of the proposed action on the delivery of quality patient care in the Hospital.

ARTICLE VII - MEDICAL STAFF OFFICERS

A. Officers of the Staff

The Officers shall include:

1) Chief of Staff;
2) Vice Chief and Chief Elect;
3) Secretary/Treasurer; and
4) Immediate Past Chief

B. Qualifications

Officers must be regular members of the Active Staff at the time of the nomination and election, and must remain Active Staff Members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved, although this requirement may be waived by a vote of the Nominating Committee in cases of minor infractions. The Chief of Staff, and the Vice Chief and Chief Elect must possess demonstrated competence in their fields of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of Hospital and Staff activities.

C. Election and Term of Office

In each even year, the Nominating Committee shall recommend a slate of Officers for nomination to be presented at the annual meeting of the Staff. Staff Officer elections shall be held in each even year. The Staff Officers shall be elected by a simple majority of the regular Active Staff Members present at the annual meeting of the Staff and shall hold office until a successor is elected and qualified. Officers shall take office on the first day of the new calendar year.

D. Vacancies

Vacancies in office, other than those of Chief of Staff and Vice Chief /Chief Elect, shall be filled by the Medical Executive Committee upon a vote of a majority of its members. If there is a vacancy in the office of Chief of Staff, the Vice Chief /Chief Elect shall serve the remainder of the term. A vacancy in the office of Vice Chief and Chief Elect shall be filled by a special election conducted as reasonably soon after the vacancy occurs as possible, following the mechanism outlined for an annual election.

E. Duties

1) Chief of Staff

The Chief of Staff shall serve as the Chief Administrative Officer and principal elected official of the Staff and as Chairman of the Medical Executive Committee. The Chief of Staff's duties shall be to:

a) aid in coordinating the activities and concerns of the Administration and of the Hospital Nursing Services and other Patient Care Services with those of the Staff;

b) develop and implement in cooperation with the Department Chairmen methods for the evaluation and review of Practitioner qualifications and professional competency, continuing education programs, utilization review, concurrent monitoring of the Staff practice, and retrospective patient care audits;

c) communicate and represent the opinions, policies, concerns, needs and grievances of the Staff to the Board, the Administrator and other officials of the Hospital Authority, for implementation of sanctions when these are required, and for the Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Staff Member;

d) call, preside at, and be responsible for the agenda of all regular and called meetings of the Staff;

e) serve as an ex officio voting member of all standing Committees of the Staff; and

f) attend all regularly scheduled monthly meetings of the Board.

2) Vice Chief / Chief Elect

The Vice Chief, who shall also be designated as the Chief Elect, shall perform the duties of the Chief of Staff in the absence of the Chief of Staff. He or she shall also perform such other duties as may be assigned to him or her to assist the Chief of Staff. The Vice Chief shall be a voting member of the Medical Executive Committee.

3) Secretary/Treasurer

The Secretary/Treasurer shall supervise the recording and maintenance of complete minutes of all regular and called meetings of the Staff, shall send out notice of called meetings, shall attend to all correspondence of the Staff and shall perform other duties as ordinarily handled by his or her office. The Secretary/Treasurer will be responsible and accountable for any funds belonging to the Staff. The Secretary/Treasurer shall be a voting member of the Medical Executive Committee.

4) Immediate Past Chief

The Immediate Past Chief shall perform the duties of the Chief of Staff in the absence of the Chief of Staff and the Vice Chief. The Immediate Past Chief shall also serve in an advisory capacity, assist the current Officers, serve on the Hospital Authority Planning Committee and present monthly reports to the Medical Executive Committee and the Medical Staff about that Committee's activities.

5) Assistance of Medical Director

In the event there is a Medical Director in office, any Officer of the Staff may utilize the assistance of the Medical Director and the staff of Medical Staff Services in performing any of his or her duties, as described above.

F. Removal

An Officer of the Staff may be removed from office by two-thirds (2/3^{rds}) vote of the regular Active Staff Members eligible to vote for Staff Officers. Removal may be initiated by any member of the Staff by written request to the Medical Executive Committee, including the basis for requesting such removal. Within fourteen (14) days after receipt of a written request, the Medical Executive Committee shall either appoint a special Committee to investigate the complaint or forward a recommendation to the Medical Staff for action. If appointed, the special Committee shall submit a written report and recommendation to the Medical Executive Committee within fourteen (14) days after being appointed. Within fourteen (14) days of receipt of the written report from the special Committee, the Medical Executive Committee shall forward its recommendation to the Medical Staff for action.

ARTICLE VIII - GENERAL STAFF MEETINGS

A. Annual Meeting

The annual meeting of the Staff shall be the last regular meeting before the end of the calendar year. At this meeting, the retiring Officers and Committees shall make such reports as may be desirable and Officers for the ensuing year shall be elected.

B. Bimonthly Meetings

Regular meetings of the Staff will be held on the third (3rd) Tuesday of every other month. In addition to matters of organization, the programs of such meeting will include a report of actions of the Executive Committee.

C. Special Meetings

Special meetings of the Staff may be called at any time by:

1) The Chief of Staff;

2) The Medical Executive Committee; or

3) The Secretary/Treasurer, upon receipt of a written request from twenty-five percent (25%) or more of the regular members of the Active Staff.

Notice of a special meeting shall be made in writing at least seven (7) business days prior to the date of the meeting. At any special meeting no business shall be transacted other than that stated in the notice of the called meeting and a quorum as defined in Article VIII, E. below shall be required.

D. Minutes

Minutes of the meetings shall be taken by the Secretary/Treasurer and shall include attendance and votes on each matter.

E. Quorum; Voting Requirements

A quorum for all purposes shall consist of the regular and provisional Active Staff Members who are eligible to vote and are present at the meeting. Each Active Staff Member who is eligible to vote and is present at the meeting has one (1) vote. The Chief of Staff, in his or her discretion, may adjourn the meeting from time to time without notice other than announcement at the meeting. The use of proxies by Staff Members is prohibited. At any meeting at which a quorum is present, business may be transacted by a majority vote of those regular Active and eligible provisional status Staff Members present and voting.

F. Attendance Requirements

Regular Active Staff Members and all provisional status Staff Members shall be required to attend one-half (1/2) of the regular meetings within any calendar year or faction thereof, unless absences are excused. A list of acceptable excuses shall be set forth in the Rules and Regulations of the Staff, as adopted from time to time pursuant to Article XV. Failure to meet the attendance requirements shall result in the loss, for one (1) year, of the Staff Member's Medical Staff voting privileges and his or her eligibility to serve on the Medical Executive Committee.

G. Assessments

By a majority vote at a meeting of the Staff, the Staff may assess Staff Members to finance Staff activities and functions, excluding political purposes. By accepting the rights and obligations of Staff Membership, each Member is obligated to make full and prompt payment of any such assessment. Failure to meet this obligation may result in corrective action and the imposition of any of the sanctions permitted pursuant to Articles XI and XII.

ARTICLE IX - DEPARTMENTS OF THE MEDICAL STAFF

A. General Provisions

Each Staff Member shall belong to a functioning Department and Service at each Hospital campus at which the Staff Member maintains Clinical Privileges and participate in the regular functions of such Department and Service. The Departments, as much as is practical, will be autonomous units coordinating their efforts through the Medical Executive Committee and other Committees of the Staff as necessary for administrative functioning.

B. Clinical Departments; Services

1) Departments shall be:

a) Surgery; and

b) Medicine.

2) Services under the Department of Surgery shall be:

a) General Surgery, which shall include the following Section:

i) Vascular Surgery;

b) Thoracic Surgery, which shall include the following Section:

i) Cardiovascular/Thoracic Surgery;

c) Plastic Surgery;

d) Orthopedic Surgery;

e) Urology;

f) Ophthalmology;

g) Otolaryngology;

h) Obstetrics and Gynecology;

i) Anesthesiology;

j) General Dentistry;

k) Oral and Maxillofacial Surgery;

l) Neurological Surgery;

m) Emergency Medicine;

n) Pathology; and

o) Pain Medicine.

3) Services under the Department of Medicine shall be:

a) Internal Medicine, which shall include the following Sections:

i) Gastroenterology & Gastrointestinal Endoscopy;

ii) Cardiology, Invasive and/or Noninvasive;

iii) Hematology/Oncology;

iv) Rheumatology;

v) Pulmonary Disease;

vi) Endocrinology;

vii) Infectious Diseases;

viii) Nephrology;

ix) Allergy/Immunology; and

x) Critical Care.

b) Family Practice;

c) General Practice;

d) Pediatric, which shall include the following Sections:

i) Pediatric Allergy/Immunology;

ii) Pediatric Cardiology;

iii) Pediatric Nephrology;

iv) Pediatric Pulmonology;

v) Neonatology;

e) Dermatology;

f) Psychiatry;

g) Neurology;

h) Radiology/Nuclear Medicine/Radiation Oncology; and

i) Physical Medicine and Rehabilitation

Each Service may be organized with Sections and sub-Sections, subject to the approval of the Medical Executive Committee and the Board.

C. Special Requirements of Services and Sections

The following constitute special requirements for the respective Services and Sections listed; provided, however, that any Service or Section requirement that a Doctor of Medicine be Board Certified by or meet the training and experience and any time limit requirements for certification by an American Board of Medical Specialties Member Board and any Service or Section requirement that a Doctor of Osteopathy meet the post-graduate training and experience requirements designated by the applicable American Board of Medical Specialties Member Board shall apply only to individuals making initial application for Clinical Privileges in such Service or Section after January 1, 1999. Doctors of Osteopathy making initial application after January 1, 2012 must be Board Certified by or meet the post-graduate training and experience requirements designated by either the applicable American Board of Medical Specialties Member Board or the American Osteopathic Association Specialty Certifying Board.

1) Department of Surgery

a) General Surgery: Doctors of Medicine applying for Staff Membership in the Service of General Surgery must be Board Certified by the American Board of Surgery or meet the training and experience and any time limit requirements for certification by the American Board of Surgery. Doctors of Osteopathy applying for Staff Membership in the Service of General Surgery must be Board Certified by the American Osteopathic Board of Surgery or meet the post-graduate training and experience requirements designated by the American Board of Surgery or the American Osteopathic Board of Surgery.

b) Thoracic Surgery: Doctors of Medicine applying for Staff Membership in the Service of Thoracic Surgery must be Board Certified by the American Board of Thoracic Surgery or meet the training and experience and any time limit requirements for certification by the American Board of Thoracic Surgery. Doctors of Osteopathy applying for Staff Membership in the Service of Thoracic Surgery must be Board Certified by the American Osteopathic Board of Surgery, Primary Certification in Thoracic Cardiovascular Surgery or meet the post-graduate training and experience requirements designated by the American

Board of Thoracic Surgery or the American Osteopathic Board of Surgery, Primary Certification in Thoracic Cardiovascular Surgery.

c) Plastic Surgery: Doctors of Medicine applying for Staff Membership in the Service of Plastic Surgery must be Board Certified by the American Board of Plastic Surgery or meet the training and experience and any time limit requirements for certification by the American Board of Plastic Surgery. Doctors of Osteopathy applying for Staff Membership in the Service of Plastic Surgery must be Board Certified by the American Osteopathic Board of Surgery, Primary Certification in Plastic & Reconstructive Surgery or meet the post-graduate training and experience requirements designated by the American Board of Plastic Surgery or the American Osteopathic Board of Surgery, Primary Certification in Plastic & Reconstructive Surgery.

d) Orthopedics: Doctors of Medicine applying for Staff Membership in the Service of Orthopedics must be Board Certified by the American Board of Orthopedic Surgery or meet the training and experience and any time limit requirements for certification by the American Board of Orthopedic Surgery. Doctors of Osteopathy applying for Staff Membership in the Service of Orthopedics must be Board Certified by the American Osteopathic Board of Orthopedic Surgery or meet the post-graduate training and experience requirements designated by the American Board of Orthopedic Surgery or the American Osteopathic Board of Orthopedic Surgery.

e) Urology: Doctors of Medicine applying for Staff Membership in the Service of Urology must be Board Certified by the American Board of Urology or meet the training and experience and any time limit requirements for certification by the American Board of Urology. Doctors of Osteopathy applying for Staff Membership in the Service of Urology must be Board Certified by the American Osteopathic Board of Surgery, Primary Certification in Urological Surgery or must meet the post-graduate training and experience requirements designated by the American Board of Urology or the American Osteopathic Board of Surgery, Primary Certification in Urological Surgery.

f) Ophthalmology: Doctors of Medicine applying for Staff Membership in the Service of Ophthalmology must be Board Certified by the American Board of Ophthalmology or meet the training and experience and any time limit requirements for certification by the American Board of Ophthalmology. Doctors of Osteopathy applying for Staff Membership in the Service of Ophthalmology must be Board Certified by the American Osteopathic Board of Ophthalmology & Otolaryngology- Head & Neck Surgery, Primary Certification in Ophthalmology or meet the post-graduate training and experience requirements designated by the American Board of Ophthalmology or the American Osteopathic Board of Ophthalmology & Otolaryngology- Head & Neck Surgery, Primary Certification in Ophthalmology.

g) Otolaryngology: Doctors of Medicine applying for Staff Membership in the Service of Otolaryngology must be Board Certified by the American Board of Otolaryngology or meet the training and experience and any time limit requirements for certification by the American Board of Otolaryngology. Doctors of Osteopathy applying for Staff Membership in the Service of Otolaryngology must be Board Certified by the American Osteopathic Board of Ophthalmology & Otolaryngology-Head and Neck Surgery, Primary Certification in Otolaryngology or meet the post-graduate training and experience requirements designated by the American Board of Otolaryngology or the American Osteopathic Board of Ophthalmology & Otolaryngology-Head and Neck Surgery, Primary Certification in Otolaryngology.

h) Obstetrics and Gynecology: Doctors of Medicine applying for Staff Membership in the Service of Obstetrics and Gynecology must be Board Certified by the American Board of Obstetrics and Gynecology or meet the training and experience and any time limit requirements for certification by the American Board of Obstetrics and Gynecology. Doctors of Osteopathy applying for Staff Membership in the Service of Obstetrics and Gynecology must be Board Certified by the American Osteopathic Board of Obstetrics and Gynecology or meet the post-graduate training and experience requirements designated by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics & Gynecology.

i) Anesthesiology: Doctors of Medicine applying for Staff Membership in the Service of Anesthesiology must be Board Certified by the American Board of Anesthesiology or meet the training and experience and any time limit requirements for certification by the American Board of Anesthesiology. Doctors of Osteopathy applying for Staff Membership in the Service of Anesthesiology must be Board Certified by the American Osteopathic Board of Anesthesiology or meet the post-graduate training and experience requirements designated by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology.

j) General Dentistry: Dentists applying for Staff Membership in the General Dentistry Service must: (i) be graduates of an American Dental Association accredited dental school; and (ii) meet the training and experience requirements designated by the American Dental Association. The Applicant will specify the extent and types of Clinical Privileges he or she desires and will need to demonstrate, by record of training and experience and performance, his or her eligibility for the desired Clinical Privileges. Any Dentist who holds Staff Membership in the General Dentistry Service may apply for, and obtain, new or additional Clinical Privileges in the General Dentistry Service by demonstrating adequate knowledge and/or competency of performance necessary to proper execution of the Clinical Privileges requested.

k) Oral and Maxillofacial Surgery: Oral and Maxillofacial Surgeons applying for Staff Membership in the Service of Oral and Maxillofacial Surgery must meet the post-graduate training and experience requirements designated by the American Board of Oral and Maxillofacial Surgery.

l) Neurological Surgery: Doctors of Medicine applying for Staff Membership in the Service of Neurological Surgery must be Board Certified by the American Board of Neurological Surgery or meet the training and experience and any time limit requirements for certification by the American Board of Neurological Surgery. Doctors of Osteopathy applying for Staff Membership in the Service of Neurological Surgery must be Board Certified by the American Osteopathic Board of Surgery, Primary Certification in Neurological Surgery or meet the post-graduate training and experience requirements designated by the American Board of Neurological Surgery or the American Osteopathic Board of Surgery, Primary Certification in Neurological Surgery.

m) Emergency Medicine: Doctors of Medicine applying for Staff Membership in the Service of Emergency Medicine must be Board Certified by the American Board of Emergency Medicine, American Board of Internal Medicine, American Board of Surgery, or American Board of Family Practice or meet the training, experience, and any time requirements for certification by the American Board of Emergency Medicine, American Board of Internal Medicine, American Board of Surgery, or American Board of Family Practice. Doctors of Osteopathy applying for Staff Membership in the Service of Emergency Medicine must be Board Certified by the American Osteopathic Board of Emergency Medicine, American Osteopathic Board of Internal Medicine, American Osteopathic Board of Surgery, or the American Osteopathic Board of Family Physicians or meet the post-graduate training and experience requirements designated by the American Board of Emergency Medicine, American Osteopathic Board of Emergency Medicine, American Board of Internal Medicine, American Osteopathic Board of Internal Medicine, American Board of Surgery, American Osteopathic Board of Surgery, American Board of Family Practice or the American Osteopathic Board of Family Physicians. Applicants without certification by the American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine shall present evidence of sufficient training and experience in high acuity Emergency Medicine. He or she may obtain new or additional Clinical Privileges in the Medical or Surgical Department by demonstrating adequate knowledge and/or competence of performance necessary for proper execution of the Clinical Privileges requested.

All Staff Members shall have Clinical Privileges in Emergency Medicine, within the limitations of his or her Clinical Privileges in other Services or Departments, but only those Staff Members whose primary

function is in the area of emergency primary care shall be members of the Emergency Medicine Service.

Members of the Emergency Medicine Service shall not be restricted to emergency primary care, but can function in other areas within the limitations of their Clinical Privileges. Each Emergency Medicine Service Staff Member shall have Clinical Privileges in one or more Departments in accordance with privileges granted him or her in each Department. He or she shall be subject to the jurisdiction of each Department Chairman and Chief of the Emergency Medicine Service.

Each Emergency Medicine Service member shall be assigned to the Emergency Medicine Service, which shall be included in the Department for purposes such as holding office and fulfilling other obligations of Staff Membership.

A physician who is presently serving his/her final year of a residency in Emergency Medicine, recognized by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, is recommended and approved as described in Article V, C. (2), (c), may be granted Temporary Clinical Privileges for a Specific Need, not to exceed one (1) year, provided his/her provision of patient care is directly supervised by an Active Staff Member of the Emergency Medicine Service and the quality of work is monitored by the Medical Director of Emergency Medicine Service.

n) Pathology: Doctors of Medicine applying for Staff Membership in the Service of Pathology must be Board Certified by the American Board of Pathology or meet the training and experience and any time limit requirements for certification by the American Board of Pathology. Doctors of Osteopathy applying for Staff Membership in the Service of Pathology must be Board Certified by the American Osteopathic Board of Pathology, Primary Certification in Anatomic Pathology & Laboratory Medicine or meet the post-graduate training and experience requirements designated by the American Board of Pathology or the American Osteopathic Board of Pathology, Primary Certification in Anatomic Pathology & Laboratory Medicine.

o) Pain Medicine: Doctors of Medicine applying for Staff Membership in the Service of Pain Medicine must be: Board Certified by the American Board of Anesthesiology, sub-specialty Certification in Pain Medicine, the American Board of Physical Medicine and Rehabilitation, sub-specialty Certification in Pain Medicine, or the American Board of Psychiatry and Neurology, sub-specialty Certification in Pain Medicine; or meet the training and experience and any time limit requirements for certification by the American Board of Anesthesiology, sub-specialty Certification in Pain Medicine, the American Board of Physical Medicine and Rehabilitation, sub-specialty Certification in Pain Medicine, or the American Board of Psychiatry and Neurology, sub-specialty Certification

in Pain Medicine. Doctors of Osteopathy applying for Staff Membership in the Service of Pain Medicine must be: Board Certified by the American Osteopathic Board of Anesthesiology, Certification of Added Qualifications in Pain Management; or meet the post-graduate training and experience requirements designated by the American Board of Anesthesiology, sub-specialty Certification in Pain Medicine, the American Board of Physical Medicine and Rehabilitation, sub-specialty Certification in Pain Medicine, or the American Board of Psychiatry and Neurology, sub-specialty Certification in Pain Medicine, or the American Osteopathic Board of Anesthesiology, Certification of Added Qualifications in Pain Management.

p) Critical Care: Doctors of Medicine applying for Staff Membership in the Service of Critical Care must be Board Certified by the American Board of Anesthesiology, sub-specialty Certification in Critical Care Medicine, the American Board of Surgery, sub-specialty Certification in Surgical Critical Care, or the American Board of Emergency Medicine, sub-specialty Critical Care Medicine or meet the training and experience and any time limit requirements for certification by the American Board of Anesthesiology, sub-specialty Certification in Critical Care Medicine, American Board of Emergency Medicine, sub-specialty Critical Care Medicine, or American Board of Surgery, sub-specialty Certification in Surgical Critical Care. Doctors of Osteopathy applying for Staff Membership in the Service of Critical Care must be Board Certified by the American Osteopathic Board of Anesthesiology, Certification of Added Qualification in Critical Care Medicine, or the American Osteopathic Board of Surgery, Certification of Added Qualification in Surgical Critical Care, or meet the post-graduate training and experience requirements designated by the American Board of Anesthesiology, sub-specialty Certification in Critical Care Medicine, American Board of Emergency Medicine, sub-specialty Critical Care Medicine, the American Board of Surgery, sub-specialty Certification in Surgical Critical Care or the American Osteopathic Board of Anesthesiology, Certification of Added Qualification in Critical Care Medicine, or American Osteopathic Board of Surgery, Certification of Added Qualification in Surgical Critical Care.

Membership in the Critical Care Service is not required to exercise Clinical Privileges in any critical care unit or intensive care unit.

2) Department of Medicine

a) Internal Medicine: Doctors of Medicine applying for Staff Membership in the Service of Internal Medicine must be Board Certified by the American Board of Internal Medicine or meet the training and experience and any time limit requirements for certification by the American Board of Internal Medicine. Doctors of Osteopathy applying for Staff Membership in the Service of Internal Medicine must be Board Certified by the American Osteopathic Board of Internal Medicine or meet the post-graduate training and experience requirements designated by the

American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.

i) Gastroenterology: Doctors of Medicine applying for Staff Membership in the Service of Gastroenterology must be Board Certified by the American Board of Internal Medicine, sub-specialty of Gastroenterology or meet the training and experience and any time limit requirements for certification by the American Board of Internal Medicine, sub-specialty of Gastroenterology. Doctors of Osteopathy applying for Staff Membership in the Service of Gastroenterology must be Board Certified by the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Gastroenterology or meet the post-graduate training and experience designated by the American Board of Internal Medicine, sub-specialty of Gastroenterology or the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Gastroenterology.

ii) Nephrology: Doctors of Medicine applying for Staff Membership in the Service of Nephrology must be Board Certified by the American Board of Internal Medicine, sub-specialty of Nephrology or meet the training and experience and any time limit requirements for certification by the American Board of Internal Medicine, sub-specialty of Nephrology. Doctors of Osteopathy applying for Staff Membership in the Service of Nephrology must be Board Certified by the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Nephrology or meet the post-graduate training and experience requirements designated by the American Board of Internal Medicine, sub-specialty of Nephrology or the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Nephrology.

iii) Hematology/Oncology: Doctors of Medicine applying for Staff Membership in the Service of Hematology/Oncology must be Board Certified by the American Board of Internal Medicine, sub-specialty of Hematology/Oncology or meet the training and experience and any time limit requirements for certification by the American Board of Internal Medicine, sub-specialty of Hematology/Oncology. Doctors of Osteopathy applying for Staff Membership in the Service of Hematology/Oncology must be Board Certified by the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Hematology/Oncology or meet the post-graduate training and experience requirements designated by the American Board of Internal Medicine, sub-specialty of Hematology/Oncology or the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Hematology/Oncology.

iv) Cardiology: Doctors of Medicine applying for Staff Membership in the Service of Cardiology must be Board Certified by the American Board of Internal Medicine, sub-specialty of Cardiology or meet the training and experience and any time limit requirements for certification by the American Board of Internal Medicine, sub-specialty of Cardiology. Doctors of Osteopathy applying for Staff Membership in the Service of Cardiology must be Board Certified by the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Cardiology or meet the post-graduate training and experience requirements designed by the American Board of Internal Medicine, sub-specialty of Cardiology or the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Cardiology.

v) Rheumatology: Doctors of Medicine applying for Staff Membership in the Service of Rheumatology must be Board Certified by the American Board of Internal Medicine, sub-specialty of Rheumatology or meet the training and experience and any time limit requirements for certification by the American Board of Internal Medicine, sub-specialty of Rheumatology. Doctors of Osteopathy applying for Staff Membership in the Service of Rheumatology must be Board Certified by the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Rheumatology or meet the post-graduate training and experience requirements designated by the American Board of Internal Medicine, sub-specialty of Rheumatology or the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Rheumatology.

vi) Pulmonary Disease: Doctors of Medicine applying for Staff Membership in the Service of Pulmonary Disease must be Board Certified by the American Board of Internal Medicine, sub-specialty of Pulmonary Disease or meet the training and experience and any time limit requirements for certification by the American Board of Internal Medicine, sub-specialty of Pulmonary Disease. Doctors of Osteopathy applying for Staff Membership in the Service of Pulmonary Disease must be Board Certified by the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Pulmonology Diseases or meet the post-graduate training and experience requirements designated by the American Board of Internal Medicine, sub-specialty of Pulmonary Disease or the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Pulmonology Diseases.

vii) Endocrinology: Doctors of Medicine applying for Staff Membership in the Service of Endocrinology must be Board Certified by the American Board of Internal Medicine, sub-specialty of Endocrinology or meet the training and experience and

any time limit requirements for certification by the American Board of Internal Medicine, sub-specialty of Endocrinology. Doctors of Osteopathy applying for Staff Membership in the Service of Endocrinology must be Board Certified by the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Endocrinology or meet the post-graduate training and experience requirements designated by the American Board of Internal Medicine, sub-specialty of Endocrinology or the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Endocrinology.

viii) Allergy/Immunology: Doctors of Medicine applying for Staff Membership in the Service of Allergy/Immunology must be Board Certified by the American Board of Internal Medicine, sub-specialty of Allergy/Immunology or meet the training and experience and any time limit requirements for certification by the American Board of Internal Medicine, sub-specialty of Allergy/Immunology. Doctors of Osteopathy applying for Staff Membership in the Service of Allergy/Immunology must be Board Certified by the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Allergy/Immunology or meet the post-graduate training and experience requirements designated by the American Board of Internal Medicine, sub-specialty of Allergy/Immunology or the American Osteopathic Board of Internal Medicine, Certification of Special Qualifications in Allergy/Immunology.

ix) Critical Care: Doctors of Medicine applying for Staff Membership in the Service of Critical Care must be Board Certified by the American Board of Internal Medicine, sub-specialty of Critical Care Medicine or meet the training and experience and any time limit requirements for certification by the American Board of Internal Medicine, sub-specialty of Critical Care Medicine. Doctors of Osteopathy applying for Staff Membership in the Service of Critical Care must be Board Certified by the American Osteopathic Board of Internal Medicine, Certification of Added Qualifications in Critical Care Medicine or meet the post-graduate training and experience requirements designated by the American Board of Internal Medicine, sub-specialty of Critical Care Medicine or the American Osteopathic Board of Internal Medicine, Certification of Added Qualifications in Critical Care Medicine.

Membership in the Critical Care Service is not required to exercise clinical privileges in any critical care unit or intensive care unit.

b) Family Practice: Doctors of Medicine applying for Staff Membership in the Service of Family Practice must be Board Certified by

the American Board of Family Practice or meet the training and experience and any time limit requirements for certification by the American Board of Family Practice. Doctors of Osteopathy applying for Staff Membership in the Service of Family Practice must be Board Certified by the American Osteopathic Board of Family Physicians or meet the post-graduate training and experience requirements designated by the American Board of Family Practice or the American Osteopathic Board of Family Physicians.

c) General Practice: Doctors of Medicine applying for Staff Membership in the Service of General Practice must have been a member of the Active Staff and a member of the Service of General Practice on or before January 19, 2005.

d) Pediatrics: Doctors of Medicine applying for Staff Membership in the Service of Pediatrics must be Board Certified by the American Board of Pediatrics or meet the training and experience and any time limit requirements for certification by the American Board of Pediatrics. Doctors of Osteopathy applying for Staff Membership in the Service of Pediatrics must be Board Certified by the American Osteopathic Board of Pediatrics or meet the post-graduate training and experience requirements designated by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics.

i) Pediatric Nephrology: Doctors of Medicine applying for Staff Membership in the Service of Pediatric Nephrology must be Board Certified by the American Board of Pediatrics, sub-specialty of Pediatric Nephrology or meet the training and experience and any time limit requirements for certification by the American Board of Pediatrics, sub-specialty of Pediatric Nephrology. Doctors of Osteopathy applying for Staff Membership in the Service of Pediatric Nephrology must be Board Certified by the American Osteopathic Board of Pediatrics and meet the post-graduate training and experience requirements designated by the American Board of Pediatrics, sub-specialty of Pediatric Nephrology.

ii) Pediatric Allergy/Immunology: Doctors of Medicine applying for Staff Membership in the Service of Pediatric Allergy/Immunology must be Board Certified by the American Board of Pediatrics, sub-specialty of Pediatric Allergy/Immunology or meet the training and experience and any time limit requirements for certification by the American Board of Pediatrics, sub-specialty of Pediatric Allergy/Immunology. Doctors of Osteopathy applying for Staff Membership in the Service of Pediatric Allergy/Immunology must be Board Certified by the American Osteopathic Board of Pediatrics, Certification of Special Qualifications in Pediatric Allergy/Immunology or meet the post-graduate training and experience requirements designated

by the American Board of Pediatrics, sub-specialty of Pediatric Allergy/Immunology or the American Osteopathic Board of Pediatrics, Certification of Special Qualifications in Pediatric Allergy/Immunology.

iii) Pediatric Pulmonology: Doctors of Medicine applying for Staff Membership in the Service of Pediatric Pulmonology must be Board Certified by the American Board of Pediatrics, sub-specialty of Pediatric Pulmonology or meet the training and experience and any time limit requirements for certification by the American Board of Pediatrics, sub-specialty of Pediatric Pulmonology. Doctors of Osteopathy applying for Staff Membership in the Service of Pediatric Pulmonology must be Board Certified by the American Osteopathic Board of Pediatrics, Certification of Special Qualifications in Pediatric Pulmonology or meet the post-graduate training and experience requirements designated by the American Board of Pediatrics, sub-specialty of Pediatric Pulmonology or the American Osteopathic Board of Pediatrics, Certification of Special Qualifications in Pediatric Pulmonology.

iv) Pediatric Cardiology: Doctors of Medicine applying for Staff Membership in the Service of Pediatric Cardiology must be Board Certified by the American Board of Pediatrics, sub-specialty of Pediatric Cardiology or meet the training and experience and any time limit requirements for certification by the American Board of Pediatrics, sub-specialty of Pediatric Cardiology. Doctors of Osteopathy applying for Staff Membership in the Service of Pediatric Cardiology must be Board Certified by the American Osteopathic Board of Pediatrics and meet the post-graduate training and experience requirements designated by the American Board of Pediatrics, sub-specialty of Pediatric Cardiology.

v) Neonatology: Doctors of Medicine applying for Staff Membership in the Service of Neonatology must be Board Certified by the American Board of Pediatrics, sub-specialty of Neonatal-Perinatal Medicine or meet the training and experience and any time limit requirements for certification by the American Board of Pediatrics, sub-specialty of Neonatal-Perinatal Medicine. Doctors of Osteopathy applying for Staff Membership in the Service of Neonatology must be Board Certified by the American Osteopathic Board of Pediatrics, Certification of Special Qualifications in Neonatology or meet the post-graduate training and experience requirements designated by the American Board of Pediatrics, sub-specialty of Neonatal-Perinatal Medicine or the American Osteopathic Board of Pediatrics, Certification of Special Qualifications in Neonatology.

vi) YouthCare: A Physician who is presently serving his/her final year of residency in Pediatrics, recognized by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association and is recommended and approved as described in Article V, C.(2)(c) of these Bylaws, may be granted Temporary Clinical Privileges for a Specific Need, not to exceed one (1) year, provided his/her provision of patient care is supervised by a readily available Active Staff Member of the Pediatrics Service and the quality of work is monitored by the Chief of Pediatrics Service.

e) Dermatology: Doctors of Medicine applying for Staff Membership in the Service of Dermatology must be Board Certified by the American Board of Dermatology or meet the training and experience and any time limit requirements for certification by the American Board of Dermatology. Doctors of Osteopathy applying for Staff Membership in the Service of Dermatology must be Board Certified by the American Osteopathic Board of Dermatology or meet the post-graduate training and experience requirements designated by the American Board of Dermatology or the American Osteopathic Board of Dermatology.

f) Psychiatry: Doctors of Medicine applying for Staff Membership in the Service of Psychiatry must be Board Certified by the American Board of Psychiatry and Neurology or meet the training and experience and any time limit requirements for certification by the American Board of Psychiatry and Neurology. Doctors of Osteopathy applying for Staff Membership in the Service of Psychiatry must be Board Certified by the American Osteopathic Board of Neurology & Psychiatry, Primary Certification in Psychiatry or meet the post-graduate training and experience designated by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology & Psychiatry, Primary Certification in Psychiatry.

g) Neurology: Doctors of Medicine applying for Staff Membership in the Service of Neurology must be Board Certified by the American Board of Psychiatry and Neurology or meet the training and experience and any time limit requirements for certification by the American Board of Psychiatry and Neurology. Doctors of Osteopathy applying for Staff Membership in the Service of Neurology must be Board Certified by American Osteopathic Board of Neurology & Psychiatry, Primary Certification in Neurology or meet the post-graduate training and experience designated by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology & Psychiatry, Primary Certification in Neurology.

h) Radiology: Doctors of Medicine applying for Staff Membership in the Service of Radiology must be Board Certified by the American Board of Radiology or meet the training and experience and any time limit requirements for certification by the American Board of Radiology.

Doctors of Osteopathy applying for Staff Membership in the Service of Radiology must be Board Certified by the American Osteopathic Board of Radiology or meet the post-graduate training and experience requirements designated by the American Board of Radiology or the American Osteopathic Board of Radiology.

i) Nuclear Medicine: Doctors of Medicine applying for Staff Membership in the Service of Nuclear Medicine must be Board Certified by the American Board of Radiology, sub-specialty of Nuclear Medicine or meet the training and experience and any time limit requirements for certification by the American Board of Radiology, sub-specialty of Nuclear Medicine. Doctors of Osteopathy applying for Staff Membership in the Service of Nuclear Medicine must be Board Certified by the American Osteopathic Board of Radiology, Certification of Added Qualifications in Nuclear Radiology, or the American Osteopathic Board of Nuclear Medicine, Certification of Added Qualifications in Nuclear Imaging & Therapy or meet the post-graduate training and experience requirements designated by the American Board of Radiology, sub-specialty of Nuclear Medicine or the American Osteopathic Board of Radiology, Certification of Added Qualifications in Nuclear Radiology, or the American Osteopathic Board of Nuclear Medicine, Certification of Added Qualifications in Nuclear Imaging & Therapy. This does not preclude limited activity by other specialists, which may involve the use of isotopes.

ii) Radiation Oncology: Doctors of Medicine applying for Staff Membership in the Service of Radiology Oncology must be Board Certified by the American Board of Radiology, sub-specialty of Radiation Oncology, or meet the training and experience and any time limit requirements for certification by the American Board of Radiology, sub-specialty of Radiation Oncology, or have completed a Therapeutic Radiology Training Program certified by the American College of Radiology. Doctors of Osteopathy applying for Staff Membership in the Service of Radiation Oncology must be Board Certified by the American Osteopathic Board of Radiology, Primary Certification in Radiation Oncology or meet the post-graduate training and experience requirements designated by the American Board of Radiology, sub-specialty of Radiation Oncology or the American Osteopathic Board of Radiology, Primary Certification in Radiation Oncology, or have completed a Therapeutic Training Program certified by the American College of Radiology.

i) Physical Medicine and Rehabilitation: Doctors of Medicine applying for Staff Membership in the Service of Physical Medicine and Rehabilitation must be Board Certified by the American Board of Physical Medicine and Rehabilitation or meet the training and experience and any time limit requirements for certification by the American Board of

Physical Medicine and Rehabilitation. Doctors of Osteopathy applying for Staff Membership in the Service of Physical Medicine and Rehabilitation must be Board Certified by the American Osteopathic Board of Physical Medicine and Rehabilitation or meet the post-graduate training and experience requirements designated by the American Board of Physical Medicine and Rehabilitation or the American Osteopathic Board of Physical Medicine and Rehabilitation.

D. Officers of Departments, Services & Sections

1) Election

Each Department shall elect, from among the members of the Department who are regular Active Staff Members and who either are certified by the appropriate specialty board or have established through the clinical privilege delineation process, comparable competence, a Chairman, Vice-Chairman, and a Member-at-Large ("Department Officers"). A Staff Member may not serve as a Department Officer in more than one (1) Department simultaneously. Elections for the Department Officers shall be held at the last Department meeting of the calendar year in which the applicable Department Officers' terms of office end. The Chairman, Vice-Chairman and Member-at-Large shall be elected by a majority of the regular Active Staff Members of the applicable Department eligible to vote and present at the meeting set aside for the purposes of the election; provided, however, that a quorum must be present as required by Article IX, E.(3) below. Each Service shall elect a Chief from among the members of the Service who are regular Active Staff Members and who are either certified by the appropriate specialty board or have established through the Clinical Privilege delineation process, comparable competence. The Chief shall be elected by a majority of the regular Active Staff Members of the Service eligible to vote and present at the meeting set aside for the purposes of the election; provided, however, that a quorum must be present as required by Article IX, E.(3) below. Each Section shall elect a Chief from among the members of the Section who are regular Active Staff Members and who either are certified by the appropriate specialty board or have established through the Clinical Privilege delineation process, comparable competence. The Chief shall be elected by a majority of the regular Active Staff Members of the Section eligible to vote and present at the meeting set aside for the purposes of the election; provided, however, that a quorum must be present as required by Article IX, E.(3) below. In the event the members fail to elect a Chief, the Medical Executive Committee shall appoint the Chief. In the event a Section or Service has no member who is eligible or willing to serve as Chief, the Medical Executive Committee may appoint, as Acting Chief, a Service or Section Member who has Clinical Privileges and practices. The Acting Chief is eligible to attend meetings, represent the Service or Section and make recommendations, but is not eligible to vote.

2) Term

Department Officers shall serve for a term of two (2) years and thereafter until a successor is elected from the Department. The term of office of the Chairman and

Vice-Chairman of the Department of Medicine and the term of office of the Department of Surgery Member-at-Large shall begin in even years. The term of office of the Chairman of the Department of Surgery, and the term of office of the Department of Medicine Member-at-Large shall begin in odd years. The Chief of each Service and Chief of each Section shall serve for a term of one (1) year and thereafter until a successor is elected. Such Officers and Members-at-Large shall be eligible to succeed themselves.

3) Vacancy

If a vacancy in the office of any Chairman, Vice-Chairman or Member-at-Large of a Department, any Chief of a Service or any Chief of a Section occurs, the vacancy shall be filled by a special election conducted as reasonably soon after the vacancy occurs as possible following the mechanism outlined for an annual election.

4) Removal

A Department Chairman, Vice-Chairman, or Member-at-Large may be removed by a two-thirds (2/3^{rds}) vote of the Department's regular Active Staff Members. A Department Chairman, Vice-Chairman or Member-at-Large cannot appeal such a decision as long as it does not directly interfere with the exercise of his or her Clinical Privileges at the Hospital. A Department Chairman, Vice-Chairman or Member-at-Large suspended from the Staff shall be replaced by special election of the Department. A Chief of Service may be removed by a two-thirds (2/3^{rds}) vote of the Service's regular Active Staff Members. A Chief of Service cannot appeal such a decision as long as it does not directly interfere with the exercise of his or her Clinical Privileges at the Hospital. A Chief of Service suspended from the Staff shall be replaced by special election of the Service. A Section Chief may be removed by a two-thirds (2/3^{rds}) vote of the Section's regular Active Staff Members. A Section Chief cannot appeal such a decision as long as it does not directly interfere with the exercise of his or her Clinical Privileges at the Hospital. A Section Chief suspended from the Staff shall be replaced by special election of the Section.

5) Duties

a) Department Chairman

The duties of the Department Chairman shall be as follows:

i) if serving as Chairman of the Department of Surgery or Chairman of the Department of Medicine, serve on the Medical Executive Committee as a member thereof;

ii) maintain continuing review and assessment of, and account to the Medical Executive Committee for all professional and administrative activities within his or her Department, particularly for the quality of patient care and treatment, care and services, his

or her Department and the control of the performance evaluation, improvement and other quality maintenance functions delegated to his or her Department;

iii) develop, implement and maintain Departmental programs, in cooperation with the Chief of Staff, for evaluation of Practitioner qualifications and professional competency, continuing medical education, utilization review, quality assurance, quality control, evaluation and observation of initial appointees, concurrent monitoring of professional practice in his or her Department, and retrospective patient care audit;

iv) provide guidance to the Medical Executive Committee on the overall medical policy of the Hospital Authority, and make specific recommendations and suggestions regarding his or her own Department, including off-site sources for patient care, treatment, and services not provided by the Hospital and recommendations for space and other resources needed by members of the Department;

v) maintain continuing review of the professional performance within his or her Department of all Practitioners with Clinical Privileges or Clinical Functions and all Allied Health Professionals with Clinical Functions in his or her Department and report thereon to the Medical Executive Committee;

vi) report to the Professional Qualifications Committee and/or the Limited License Professionals and Allied Health Professionals Committee (as applicable) and the Medical Executive Committee concerning appointment and classification, including recommending specific Clinical Privileges or Clinical Functions for appointment or reappointment with respect to Applicants or Staff Members within his or her Department, and recommending corrective action of Practitioners within his or her Department;

vii) enforce the Staff's Bylaws, Policies, and Rules and Regulations within his or her Department, including initiating corrective action and investigation of the performance of Clinical Privileges within his or her Department and ordering required consultations;

viii) implement, within his or her Department, actions taken by the Medical Executive Committee or by the Board;

ix) assist in the preparation of such annual reports, including budgetary planning, pertaining to his or her Department as may be required by the Medical Executive Committee, the Administrator, or the Board;

x) coordinate and integrate inter-departmental and intra-departmental services;

xi) recommend to the Professional Qualifications Committee or the Limited License Professionals and Allied Health Professionals Committee, as applicable, criteria for Clinical Privileges or Clinical Functions that are relevant to the care provided in the Department;

xii) integrate the Department into the primary functions of the Hospital;

xiii) develop and implement policies and procedures that guide and support the provision of services;

xiv) recommend a sufficient number of qualified and competent persons to provide care or services; and

xv) perform such other duties commensurate with his or her office as may be, from time to time, reasonably requested of him or her by the Chief of Staff, the Medical Executive Committee, or the Board.

b) Department Vice-Chairman

The Department Vice-Chairman shall perform the duties of the Chairman in the absence of the Chairman. He or she shall also perform such other duties as may be assigned to him or her to assist the Chairman. However, if the Department Chairman serves on the Medical Executive Committee, the Department Chairman's duty to serve as a member of the Medical Executive Committee, cannot be performed by or delegated to the Vice-Chairman.

c) Member-at-Large

The Member-at-Large of the Department of Medicine and the Member-at-Large of the Department of Surgery shall serve on the Medical Executive Committee.

d) Chief of Service

The duties of the Chiefs of Service shall be as outlined in these Bylaws and such other duties commensurate with his or her office as may be, from time to time, reasonably requested of him or her by the Department Chairman, the Chief of Staff, the Medical Executive Committee, or the Board.

e) Section Chief

The duties of the Section Chiefs shall be as outlined in these Bylaws and such other duties commensurate with his or her office as may be, from time to time, reasonably requested of him or her by the Chief of Service, the Department Chairman, the Chief of Staff, the Medical Executive Committee, or the Board.

E. Departmental Meetings

1) Regular and Special Meetings

Departments shall meet at least quarterly to conduct business and the functions of the Department. Special meetings may be called at any time by the Chairman and shall be called by the Secretary upon receipt of a written request from any ten (10) or more Staff Members assigned to that Department. Notice of any special meeting shall be made in writing at least five (5) business days prior to the date of the meeting. At any special meeting, no business shall be transacted other than that stated in the notice of the called meeting, and a quorum as defined in Article IX, E.(3) below shall be required.

2) Attendance Requirements

Regular members of the Active Staff and all provisional status Staff Members shall be required to attend one-half (1/2) of the regular Department meetings within any calendar year, or fraction thereof, unless absences are excused. A list of acceptable excuses shall be set forth in the Staff Rules and Regulations. Failure to meet the attendance requirements shall result in the loss, for one (1) year, of the Staff Member's Medical Staff voting privileges and his or her eligibility to serve on the Medical Executive Committee.

3) Quorum; Voting Requirements

Thirty-three and one-third percent (33-1/3%) of the regular Active and eligible provisional status Staff Members of a Department shall constitute a quorum for the conducting of all Departmental business at a regularly scheduled or specially called meeting. At any meeting at which a quorum is present, business may be transacted by a majority of those regular Active and eligible provisional status Staff Members present and voting.

F. Functions of Departments

1) Emergency Room and Back-Up

Subject to Medical Executive Committee and Board approval, each Department shall recommend the appropriate level of responsibility of its Staff Members to the emergency room and for back-up treatment and consultation. These requirements will be clearly stated in the Staff Policies or Rules and Regulations.

2) Privileges

Each Department shall establish criteria for the granting of Clinical Privileges within the Department and submit recommendations regarding the specific Clinical Privileges each Staff Member or Applicant may exercise.

3) Monitoring

Each Department will monitor, on a continuing and concurrent basis, adherence to:

a) Staff and Hospital Authority Bylaws, Policies, and Rules and Regulations;

b) Requirements for alternative coverage and for consultations; and

c) Sound principles of clinical practice.

4) Coordination of Patient Care

Departments will coordinate the patient care provided by the Department's Staff Members with Nursing and Ancillary Patient Care Services and with Administrative Support Services.

5) Professionalism

Departments will foster an atmosphere of professional decorum within the Department appropriate to the healing arts.

6) Quality Assessment and Improvement

Departments will implement quality assessment and improvement measures as required under the Performance Improvement/Patient Safety Plan developed and approved as set forth in Article X, T., including the development of objective criteria for screening that reflects current knowledge in clinical experience. Departments shall accept and execute those quality assurance functions delegated to them by the Quality Management Committee pursuant to Article X, T., including: (a) performance of chart review as needed, with the prior approval of the Administrator; (b) interviewing of Staff Members (or others exercising Clinical Privileges, Clinical Functions, or both) by letter or personal interview; (c) interviewing of other personnel as necessary; (d) establishment of educational requirements; (e) making of recommendations to the Medical Executive Committee for evaluation and observation and/or limiting of Clinical Privileges or Clinical Functions; and (f) periodic observation of the effectiveness of any such action taken in improving Departmental performance. Departments shall consider the findings from ongoing evaluation of the quality of patient care at each meeting.

ARTICLE X - COMMITTEES

A. General Provisions

1) Designation

Staff Committees shall include, but not be limited to, the Staff meeting as a Committee of the whole, meetings of Departments, meetings of Services, meetings of Sections, standing Committees described in these Bylaws, and special committees created by the Medical Executive Committee. The Committees described in this Article X shall be the standing Committees of the Staff. Special Committees may be created by the Medical Executive Committee or the Chairman of any Department, the Chief of any Service or any Section Chief to perform specified tasks. Unless otherwise provided in these Bylaws, the Chairman or co-chairmen and members of all standing Committees shall be appointed by and may be removed by the Chief of Staff subject to consultation with and approval by the Medical Executive Committee. Chairmen of all Medical Staff Committees and all members of the Medical Executive Committee, Bylaws Committee, Professional Qualifications Committee, and Quality Management Committee must be Active Staff Members. The Chief of Staff may choose to combine Committees, subject to the approval of the Medical Executive Committee. Unless otherwise provided in these Bylaws, where Committees are composed of both Staff Members and non-Staff personnel, the voting members of all Committees shall be only the Staff Members. Staff Committees shall be responsible to the Medical Executive Committee.

2) Terms of Committee Members

Committee members shall be appointed for a term of at least two (2) years and shall serve until the end of this period or until the member's successor is appointed, unless: (a) otherwise specified in these Bylaws; (b) the member serves on the Committee in his or her capacity due to Staff position; or (c) the member shall sooner resign or be removed from the Committee. The terms of Medical Executive Committee members and Committee members serving on Committees due to Staff positions shall coincide with each Officer's term as a Staff Officer or a Department Officer.

3) Removal

If a Staff member of a Committee ceases to be a Staff Member in good standing, suffers a loss or significant limitation of Clinical Privileges, or if any other good cause exists, that member may be removed by the Medical Executive Committee or the Chief of Staff.

4) Vacancies

Unless otherwise specifically provided, vacancies on any Committee shall be filled in the same manner in which an original appointment to such Committee is made.

5) Peer Review Committees and Confidentiality

The following Committees perform peer review and medical review functions and are peer review committees and/or medical review committees pursuant to O.C.G.A. §§31-7-15, 31-7-130 et seq., and 31-7-140 et seq.:

a) Medical Executive Committee;

b) Bioethics Committee;

c) Bylaws Committee;

d) Continuing Medical Education Committee;

e) Professional Qualifications Committee;

f) Critical Care Committee;

g) Emergency Patient Care Committee;

h) Infection Prevention and Control Committee;

i) Joint Conference Committee;

j) Limited License Professionals and Allied Health Professionals Committee;

k) Medical Records Committee;

l) Medical Staff Support Committee;

m) Nursery/NICU/Pediatrics Committee;

n) Oncology (Cancer) Committee;

o) Operating Room Committee;

p) Pharmacy and Therapeutics Committee;

q) Physician Resource Development Committee;

r) Quality Management Committee (including Medicine and Surgery Divisions);

s) Utilization Review Committee;

t) Neuro Care Team;

u) Trauma Committee; and

v) Any two (2) of the individuals identified in Article XI, C.(1) who confer and consider the imposition of Precautionary Suspension or Restriction.

Special Committees created pursuant to these Bylaws may also perform peer review and medical review functions and such Special Committees shall be considered peer review committees and/or medical review committees pursuant to O.C.G.A. §§ 31-7-15, 31-7-130 et seq., and 31-7-140 et seq.

All proceedings involving peer review and medical review must be held in the strictest confidence and shall not be discussed or disseminated outside the proceedings of these Committees, except as provided in these Bylaws and as required by law. Any breach of this confidentiality by Committee members or members of the Staff will be considered grounds itself for disciplinary action.
The activities and functions of Committees performing peer review and medical review functions, including activities of persons acting at these Committees' direction and request, constitute peer review and medical review activities and are entitled to protection afforded by Georgia peer review and medical review privileges.

6) Quorum; Voting Requirements; Executive Sessions

Except as otherwise specifically provided in this Article X, thirty-three and one-third percent (33-1/3%) of the voting members of a Committee shall constitute a quorum for the conducting of all Committee business at any meeting. Except as otherwise provided in these Bylaws, where Committees are composed of both Staff Members and non-Staff personnel, the voting members of all Committees shall be only the Staff Members. At any meeting at which a quorum is present, business may be transacted by a vote of thirty-three and one-third percent (33-1/3%) of all the Committee members (whether present or not). Any Committee may meet in executive session, with only voting members present, upon the affirmative vote of a majority of the voting members present.

B. Medical Executive Committee

1) Composition

The Medical Executive Committee (MEC) shall consist of: the Officers of the Staff; the Department of Surgery Chairman and Member-at-Large; the Department of Medicine Chairman and Member-at-Large; a representative of the Emergency Department to be chosen by the Department of Surgery; and a representative of the Hospitalist/Intensivist service to be chosen by the

Department of Medicine. The Chief of Staff shall act as Chairman. The CEO, the Administrator or his or her designee, the Medical Director (Chief Medical Officer) and the Assistant Administrator for Patient Care Services (Chief Nursing Officer) shall attend meetings of the Committee on an ex-officio basis, without a vote. A member of the staff of Medical Staff Services may attend the meetings for the purpose of preparing minutes of the meetings. General Counsel for the Hospital and General Counsel for the Medical Staff shall attend as requested by MEC.

The majority of the members of the Medical Executive Committee must be regular Active Staff Members.

2) Term of Membership

Officers of the Staff, Department Chairmen and Members-at-Large shall serve on the Medical Executive Committee during his/her term of Staff/Department office.

3) Duties

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

a) representing and acting on behalf of the Staff in the intervals between Staff meetings, subject to such limitations as may be imposed by these Bylaws;

b) coordinating and implementing the professional and organizational activities and policies of the Staff;

c) receiving and acting upon reports and recommendations from the Staff Departments and Committees;

d) recommending action to the Board on matters of a medical-administrative nature;

e) establishing the structure of the Staff, the mechanism to evaluate and review the qualifications and the professional competency of Practitioners and delineate individual Clinical Privileges, the organization of quality assurance activities and mechanisms of the Staff, termination of Staff Membership and corrective action procedures, as well as other matters relevant to the operation of an organized Staff;

f) evaluating the medical care rendered to patients in the Hospital and otherwise performing peer review functions and oversight for the medical staff;

g) participating in the development of Staff and Hospital Authority policy, practice, and planning;

h) reviewing the qualifications, performance, peer review data and professional competence and character of Applicants and Staff Members and making recommendations to the Board regarding Staff appointments and reappointments, assignments to Departments, Clinical Privileges, and corrective action;

i) reviewing the Bylaws and Staff, Department, Service and Section Policies and Rules and Regulations and recommending to the Bylaws Committee, the Medical Staff and Board, any interpretation, addition, deletion or revisions to the same as may be necessary or convenient for the proper conduct of the Staff consistent with these Bylaws;

j) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all Staff Members including the initiation of and participation in corrective or review measures when warranted;

k) taking reasonable steps to develop continuing education activities and programs for the Staff;

l) designating such Committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Staff and approving or rejecting appointment to those Committees by the Chief of Staff;

m) reporting to the Staff at each regular Staff meeting;

n) assisting in the obtaining and maintaining of accreditation;

o) appointing such special Committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Staff;

p) making recommendations to the Board regarding proposed Board actions that affect the Staff as a whole or individual members thereof;

q) making recommendations to the Board regarding proposed Board actions that affect the quality of patient care, including communicating to the Board the opinion, from a quality of care standpoint, of the Staff regarding any contract, whether proposed or in effect, between the Hospital Authority on the one hand and one or more Staff Members, other Practitioners exercising Clinical Privileges, or any entity representing such Staff Member(s) or other Practitioner(s) on the other hand; and

r) reporting appropriate matters and making recommendations to the Board at each regular meeting.

4) Meetings

The Medical Executive Committee shall meet as often as necessary as called by the Chairman, but at least once a month, and shall maintain minutes of its proceedings and actions.

5) Quorum; Voting Requirements

For the purpose of considering issues or performing duties of the Medical Executive Committee pursuant to Articles XI and XII of these Bylaws, a majority (50% + 1) of the voting members of the Medical Executive Committee shall constitute a quorum, and a majority (50% + 1) vote of those members present at such meetings shall be required for such action or decision by the Medical Executive Committee. In the event that one or more members of the Medical Executive Committee abstain, a majority (50% + 1) of those remaining voting members shall be required for such action or decision of the Medical Executive Committee. The quorum and voting requirements for the Medical Executive Committee to conduct all other business is determined pursuant to Article X, A.(6) of these Bylaws.

6) Attendance

Each member of the Medical Executive Committee shall attend at least 50% of the regular called meetings of the Medical Executive Committee each calendar year, unless absences are excused. A list of acceptable excuses shall be set forth in the Rules and Regulations of the Staff, as adopted from time to time pursuant to Article XV. Failure to meet the attendance requirements shall result in the loss, for one (1) year, of the Member's eligibility to serve on the Medical Executive Committee.

C. Bioethics Committee

1) Composition

The Bioethics Committee shall consist of such Staff Members as the Chief of Staff may appoint. It may also include nurses, lay representatives, social workers, clergy, ethicists, attorneys, the Administrator and Representatives from the Board. The Bioethics Committee shall include at least one (1) member whose primary concerns are in scientific areas, at least one (1) member whose primary concerns are in nonscientific areas and at least one (1) member who is not otherwise affiliated with the Hospital and who is not a part of the immediate family of a person affiliated with the Hospital. The Chairman shall be a regular Active Staff Member.

2) Duties

The duties of the Bioethics Committee shall include participating in:

a) development of guidelines for consideration of cases having bioethical implications;

b) development and implementation of procedures for the review of such cases;

c) development and/or review of institutional policies regarding care and treatment of such cases;

d) retrospective review of cases for the evaluation of bioethical policies and overall improvement of medical care rendered in the Hospital;

e) consultation with concerned parties to facilitate communication and aid conflict resolution; and

f) education of the Hospital Authority staff on bioethical matters.

To the extent required by law or applicable regulation, the Bioethics Committee shall function as an Institutional Review Board ("IRB") pursuant to 45 C.F.R., Part 46, Subpart A or any successor regulation. When functioning as an IRB, no member may participate in the Committee's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the Committee. The Committee may, in its discretion, invite individuals with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available to the Committee. These individuals may not vote with the Committee. The Committee shall develop and adopt such written procedures as necessary to comply with federal regulations governing IRBs.

3) Meetings

The Bioethics Committee shall meet as often as necessary at the call of its Chairman. It shall maintain minutes of its activities and report to the Medical Executive Committee.

4) Voting

All members of the Bioethics Committee are voting members.

D. Bylaws Committee

1) Composition

The Bylaws Committee shall consist of at least five (5) Staff Members, including the Chief of Staff Elect and Immediate Past Chief of Staff.

2) Duties

The duties of the Bylaws Committee shall include:

a) conducting an annual review of the Bylaws, as well as the Policies and the Rules and Regulations promulgated by the Staff and its Departments;

b) submitting recommendations to and receiving recommendations from the Medical Executive Committee for changes in these documents as necessary to comply with applicable laws, regulations and accreditation standards and to address current Staff practices; and

c) receiving and evaluating for recommendation to the Medical Executive Committee suggestions from the Staff for modification of the items specified in Article X, D.(2)(a).

3) Meetings

The Bylaws Committee shall meet as often as necessary at the call of its Chairman, but at least annually. It shall maintain minutes of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

E. Continuing Medical Education Committee

1) Composition

The Continuing Medical Education Committee shall consist of at least three (3) Staff Members from each clinical Department, appointed by the Chief of Staff. Administration shall appoint such members as it deems necessary, such as representatives from the Hospital Nursing Services and Education, although a majority of the Committee shall be Staff Members. The Chairman shall serve for a term of not less than two (2) years.

2) Duties

The duties of the Continuing Medical Education Committee shall include:

a) receiving reports of needed education from the Quality Management Committee and the Medical Executive Committee, conducting such forums, presentations and discussions as it deems

appropriate, and reporting the results of those programs to the Quality Management Committee and the Medical Executive Committee;

b) assisting the Departments and the Staff in developing and planning programs of continuing education that are designed to keep the Staff informed of significant new developments and new skills in medicine;

c) analyzing on a continuing basis the Hospital Authority's and Staff's need for professional library services;

d) suggesting educational programs that will improve patient care based on evaluation of quality assurance activities and defined needs;

e) encouraging Department interactions through combined programs; and

f) assessing and authorizing AMA continuing medical education programs.

3) Meetings

The Continuing Medical Education Committee shall meet as needed, but at least quarterly, and shall maintain minutes of its activities and report to the Medical Executive Committee, the Board, and Quality Management Committee as appropriate.

F. Professional Qualifications Committee

1) Composition

The Professional Qualifications Committee consists of six (6) Active Staff Members, three (3) from the Department of Medicine and three (3) from the Department of Surgery, each serving a three (3) year term. Each year at the last Department meeting, each Department will elect a Professional Qualifications Committee member for a term of three (3) years to replace the Department member rotating off the Professional Qualifications Committee that year. The Chairman of the Professional Qualifications Committee shall be elected on an annual basis by the Professional Qualifications Committee at its first meeting each calendar year.

2) Duties of Professional Qualifications Committee

The duties of the Professional Qualifications Committee shall include:

a) reviewing and evaluating the qualifications, i.e., licensure, training and education, qualifications, of each Practitioner applying for initial appointment, reappointment, or modification of Medical Staff Membership and/or for Clinical Privileges and, in connection therewith,

obtaining and considering the reports of the appropriate Departments, Services and Sections;

b) reviewing and evaluating the ethical status, character, professional current competence (including competence to treat age-specific patients and populations when applicable), and ability to perform the Clinical Privileges requested, and in connection therewith, obtaining and considering the peer review reports of the appropriate Departments, Services and Sections;

c) submitting required reports and Information on the qualifications of each Practitioner applying for Staff Membership or particular Clinical Privileges including recommendations with respect to appointment, membership, category, Department affiliation, Clinical Privileges and special conditions;

d) investigating, reviewing and reporting on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or current competence of any Applicant or Staff Member, in order to maintain and improve the quality of medical care rendered by the Staff;

e) reviewing, considering and making recommendations regarding appropriate Threshold Criteria for Clinical Privileges within the Hospital;

f) if requested by the Medical Executive Committee, performing the actions described in Article X, F.(2)(a)-(d) above with regard to Limited License Professionals and Allied Health Professionals; and

g) submitting periodic reports to the Medical Executive Committee on its activities and the status of the pending applications.

3) Meetings

The Professional Qualifications Committee shall meet as often as necessary. Each Committee shall maintain minutes of its proceedings and actions and shall report to the Medical Executive Committee. In the event that application(s) are pending and a meeting is held and members constituting at least a quorum are not present, if the Board is scheduled to meet within two (2) weeks, the applicable Committee shall reconvene prior to the Board meeting to consider such applications.

4) Quorum; Voting Requirements

A majority (50% + 1) of the members of the Professional Qualifications Committee shall constitute a quorum for the conducting of all business at any meeting of the applicable Committee. At any meeting at which a quorum is present, business may be transacted by a majority of the voting members present.

G. Critical Care Committee

1) Composition

The Critical Care Committee shall consist of the Chiefs of the following Sections/Services or his or her designee approved by the Chief of Staff: Cardiology, General Surgery, Internal Medicine, Pulmonary Disease, Thoracic Surgery, and representatives from the Intensivists, Anesthesiology, Pediatrics, Neurology or Neurological Surgery. Administration, after consultation with the Chairman of the Critical Care Committee, shall appoint such members as it deems necessary, such as the Director of the Hospital Nursing Service, from each of the critical care units participating in the Committee, although a majority of the Committee shall be Staff Members. The Chairman of the Critical Care Committee shall be appointed by the Chief of Staff.

2) Duties

The duties of the Critical Care Committee shall include:

a) reviewing whether the quality of critical care provided in the Hospital is consistently optimal and in compliance with the applicable standard of care by continuous evaluation through reliable and valid measures;

b) periodically reviewing the management and nursing policies of the critical care units;

c) ensuring that any Medical Directors of the critical care units are responsible for the enforcement of patient care policies;

d) establishing and directing admission and discharge policies for the various critical care units;

e) coordinating critical care provided by the Staff using the critical care units with the nurses and Hospital patient care services; and

f) adopting policies relating to the delivery of medical care in the critical care units, which shall be approved by the Medical Executive Committee and the Board. These policies shall be reviewed by the Committee annually.

3) Meetings

The Critical Care Committee shall meet as needed, but at least quarterly. The Committee shall maintain minutes of its activities and report to the Medical Executive Committee and to the Departments affected by its actions.

H. Emergency Patient Care Committee

1) Composition

The committee shall consist of the following members as appointed by the Chief of Staff: Medical Director(s) of Emergency Medicine Service; Chairman, Department of Medicine; Chief, Internal Medicine Service; Member, Department of Medicine (Hospitalist); Chairman, Department of Surgery; Chief, General Surgery Service; Member, Department of Surgery; Chief, Radiology Service; Administrative Director, Emergency Department; Assistant Administrator, Patient Care Services; Assistant Administrator, Ancillary Services; Coordinator, Emergency Medicine Services; Chief Medical Officer. The Chairman shall be designated by the Chief of Staff. Additional members may be appointed by the Chief of Staff as needed. Voting shall be limited to members of the Active Medical Staff.

2) Duties

The duties of the Emergency Patient Care Committee shall include:

a) serving as a liaison between Physicians, nurses, emergency medical technicians, and other personnel of the Emergency Room and ambulance services, and the Medical Staff and the Administration.

b) ensuring that emergency patient care is guided by written policies, supported by appropriate procedure manuals, rules and regulations of the Emergency Medicine Service;

c) ensuring that appropriate medical records are maintained on all patients cared for in the emergency room;

d) maintaining an up-to-date roster of on-call Physicians responsible for responding to emergency calls and a current list of available specialists;

e) preparing, making available, and reviewing annually written instructions on emergency measures to be instituted by the Hospital Nursing personnel in the absence of and until arrival of a Physician;

f) developing policies to ensure that the Medical Staff complies with EMTALA and does not participate in inappropriate transfers or "dumping" of patients; and

g) evaluating the quality of and taking such steps as are necessary to improve emergency patient care rendered at the Hospital.

2) Meetings

The Emergency Patient Care Committee shall meet as needed at the call of its Chairman, but at least quarterly, and shall maintain minutes of its activities and transmit written reports to the Medical Executive Committee.

I. Infection Prevention and Control Committee

1) Composition

The Infection Prevention and Control Committee shall consist of at least four (4) representatives of the Staff (one of which shall also serve as the chairman of the Committee), one (1) representative from the Hospital Nursing Service (appointed by the Hospital Nursing Service director), one (1) representative from the Pathology Service and one (1) representative of the Administration (appointed by the Administrator). Representatives of other clinical Departments and Services may be appointed by the Committee Chairman to serve as consultants to the Committee and to participate in scheduled review of infection control policies and practices in their particular areas.

2) Duties

The duties of the Infection Prevention and Control Committee shall include:

a) developing and monitoring a Hospital-wide infection control program;

b) developing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

c) developing and implementing a preventive and corrective program designed to minimize infection hazards and improve the quality of medical care rendered in the Hospital, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

d) developing written policies defining special indications for isolation requirement;

e) coordinating action on findings from the Staff's review of the clinical use of antibiotics;

f) acting upon recommendations related to infection control received from the Chief of Staff, the Medical Executive Committee, Departments and other Committees;

g) reviewing sensitivities of organisms and communicable disease reports specific to the facility;

h) developing policies for testing Hospital Authority personnel for contagious and communicable diseases; and

i) developing policies for disposing of infectious materials.

3) Meetings

The Infection Prevention and Control Committee shall meet as often as necessary at the call of its Chairman, but at least quarterly. It shall maintain minutes of its proceedings and shall submit reports of its activities and recommendations to the Medical Executive Committee.

J. Joint Conference Committee

1) Composition

The Joint Conference Committee is a discussion committee of the Board and the Medical Staff without intrinsic authority to take action, and shall be composed of four (4) members of the Board to be appointed by the Chairman of the Board and the following four (4) members of the Executive Committee of the Medical Staff: the Chief of Staff, Vice Chief and Chief Elect of Staff, Immediate Past Chief of Staff, and Secretary/Treasurer. The Administrator and the Medical Director shall be advisory members of this Committee.

2) Duties

The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital Authority and Staff policy, practice, and planning, and a forum for interaction between the Board and the Staff on such matters as may be referred by the Medical Executive Committee or the Board, or as otherwise referred to this Committee by these Bylaws.

The Joint Conference Committee shall exercise other responsibilities specifically delegated by the Board.

3) Meetings

The Joint Conference Committee shall meet at least annually, and otherwise shall meet upon the joint call of the Chairman of the Board and the Chief of Staff, and shall transmit written minutes of its activities to the Medical Executive Committee and to the Board.

4) Quorum; Voting Requirements

A quorum shall be no less than five (5) members of the Joint Conference Committee, and no business may be transacted by less than the affirmative vote of five (5) members of this Committee. All Committee members may vote.

K. Limited License Professionals and Allied Health Professionals Committee

1) Composition

The Limited License Professionals and Allied Health Professionals Committee shall consist of at least three (3) regular Active Staff Members, all of whom

interact with Limited License Professionals and Allied Health Professionals on a regular basis, and at least three (3) Limited License Professionals and Allied Health Professionals.

2) Duties

The duties of the Limited License Professionals and Allied Health Professionals Committee shall include:

a) evaluating and making recommendations regarding the need for and appropriateness of the performance of in-hospital services by Limited License Professionals and Allied Health Professionals;

b) preparing, upon the request of the Board and for adoption by the Medical Executive Committee and approval by the Board, the Manual pursuant to Article V, F.(3);

c) reviewing and evaluating the qualifications of each Limited License Professional/Allied Health Professional/Staff Member Assistant applying for initial appointment, reappointment, or modification of and for Clinical Functions for Allied Health Professionals or Staff Member Assistants or Clinical Functions and/or Clinical Privileges for Limited License Professionals, and, in connection therewith, obtaining and considering the recommendations of the appropriate Departments, Services and Sections;

d) submitting required reports and information on the qualifications of each Limited License Professional applying for Clinical Privileges and/or Clinical Functions and each Allied Health Professional or Staff Member Assistant applying for Clinical Functions, including recommending with respect to appointment, Clinical Privileges and/or Clinical Functions and special conditions; and

e) investigating, reviewing and reporting on matters referred by the Chief or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any Limited License Professional, Allied Health Professional or Staff Member Assistant.

3) Meetings

The Limited License Professionals and Allied Health Professionals Committee shall meet as needed at the call of its Chairman, but at least twice yearly, and shall maintain minutes of its activities and transmit written reports to the Medical Executive Committee.

L. Medical Records Committee

1) Composition

The Medical Records Committee shall consist of at least seven (7) Active Staff Members, a Chairman, and three (3) from the Department of Medicine and three (3) from the Department of Surgery and a Committee Chairman, appointed by the Chief of Staff. The Chairman of the Committee will appoint Hospital administrative members as needed. The Chief Medical Officer shall serve as an advisor to the Committee.

2) Duties

The duties of the Medical Records Committee shall include:

a) reviewing existing pre-printed physician order sets and protocols and working with Hospital information technology personnel and Hospital electronic medical record and order set vendors to develop proposed standard order sets and protocols for use in the Hospital;

b) recommending processes, procedures and policies to the Medical Executive Committee regarding the consideration, adoption and implementation of standard order sets;

c) reviewing all standard order sets proposed for use in the Hospital;

d) consulting with Medical Staff Members and SGMC staff regarding proposed standing orders, protocols and standard order sets as needed;

e) assisting the Medical Executive Committee and SGMC staff with efforts to implement adopted processes, procedures and policies regarding standard order sets;

f) reviewing standard order sets on a periodic basis, as further defined from time to time by Medical Staff policy;

g) reviewing medical records for their timely completion;

h) assuring that medical records reflect the admission data, condition of the patient at the time of discharge, admitting and final diagnosis, results, completeness and quality of the history and physical examination, ("H&P") which includes the content for H&Ps required by Medical Staff Policy MS 3, as amended from time to time, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient, discharge summary, and adequate identification of the individual responsible for orders given;

i) reviewing summary information regarding the timely completion of all medical records;

j) reviewing and recommending the format of the medical record, the forms used in the medical record, and the use of electronic data processing and storage systems for medical record purposes;

k) notifying Practitioners regarding deficiencies in medical records when appropriate; and

l) requesting the Committee Chairperson or Medical Director to request the Medical Executive Committee to initiate an investigation to determine whether corrective action is warranted with regard to any Practitioner who fails to comply with necessary medical record-keeping pursuant to Article XI.

3) Meetings

The Medical Records Committee shall meet as needed, but at least every other month. The Committee shall maintain minutes of its activities and report to the Medical Executive Committee and to the Departments affected by its actions.

M. Medical Staff Support Committee

1) Composition

The Medical Staff Support Committee shall consist of at least five (5) members, four (4) of whom shall be regular Active Staff Members appointed by the Chief of Staff. One or more members should be proficient in the treatment of substance abuse problems.

2) Duties

The Medical Staff Support Committee shall have as its purpose the improvement of the quality of care and the promotion of competence among Staff Members. The Medical Staff Support Committee's duties shall be:

a) to annually review the Medical Staff Support Policy and propose revisions as necessary;

b) to receive any report relating to the mental or physical health, well-being, or impairment of any Staff Member, as relevant to such Staff Member's ability to exercise the Clinical Privileges granted to, or requested by, such Staff Member;

c) to investigate such reports to the extent necessary to protect the health, welfare, and safety of patients, other Staff Members, and Hospital personnel;

d) to provide such advice, counseling, or referrals as it determines may be necessary;

e) upon the occurrence of any accident or incident in which a Staff Member's performance cannot be discounted as a contributing factor, to request such chemical test or tests of blood, breath, urine, or other bodily substances as it may deem necessary for the purpose of determining alcoholic or other drug content of the Staff Member's system, as relevant to such Staff Member's ability to exercise the Clinical Privileges granted to, or requested by, such Staff Member; and further to request such psychiatric or other medical evaluations as it shall deem necessary to determine the Staff Member's ability to exercise the Clinical Privileges granted to, or requested by, such Staff Member;

f) upon receipt of documentation of specific, contemporaneous physical, behavioral or performance indicators consistent with probable substance abuse, psychiatric or other medical conditions so as to create a reasonable suspicion that a Staff Member is using or is under the influence of alcohol or other drugs while rendering or participating in patient care or the exercise of Clinical Privileges or is suffering from some other psychiatric disorder, to request such tests or evaluations described in Article X, M.(e) above as it deems necessary;

g) to consider, in conjunction with the Professional Qualifications Committee, the Quality Management Committee or the Medical Executive Committee, as appropriate, the results of any such tests or evaluations or the refusal to consent to such testing or evaluation; to implement any intervention or other action in accordance with the impaired member policy as adopted by the Staff; and to request the Medical Director to request the Medical Executive Committee to initiate an investigation to determine whether corrective action is warranted in accordance with the provisions of Article XI when appropriate; and

h) to study matters relating to the general health and well-being of the Staff and to develop such educational programs as may be approved by the Medical Executive Committee.

The activities of the Medical Staff Support Committee shall be confidential. The refusal to consent to such testing or evaluation as requested by the Medical Staff Support Committee shall constitute grounds for a recommendation to the Medical Executive Committee and/or the Administrator for precautionary suspension or revocation of all or any portion of a Staff Member's Staff Membership or Clinical Privileges; however, any Staff Member against whom any action is taken with respect to Staff Membership or Clinical Privileges as a result of the refusal to consent to testing or as a result of any test results shall have the right to a hearing and appellate review in accordance with Article XII.

3) Meetings

The Medical Staff Support Committee shall meet as often as necessary as called by its Chairman. The Medical Staff Support Committee shall maintain minutes of its proceedings and actions as it deems advisable, but shall report its activities in their entirety to the Medical Executive Committee.

N. Nominating Committee

1) Composition

The Nominating Committee shall consist of the three (3) most recent active Immediate Past Chiefs of Staff, the most recent of which shall preside.

2) Duties

The duties of this Committee shall be to recommend a slate of the following Officers for nomination at the annual meeting of the Staff: Chief of Staff, Vice Chief /Chief Elect, Secretary, Treasure. Additional nominations for any office may be made from the floor at the annual meeting of the Staff. The Nominating Committee shall specifically take into consideration any complaints or corrective actions taken against any practitioner in nominating any individual for a medical staff office.

3) Meetings

The Nominating Committee shall meet as needed, but at least prior to the annual meeting of the Staff when elections are held.

O. Nursery/NICU/Pediatric Committee

1) Composition

The Nursery/NICU/Pediatric Committee shall consist of all Staff Members of the Pediatric Service, the Chief of the Obstetrics and Gynecology Service, the Chief of the Anesthesiology Service, designee of the Administrator, the Director of Maternal/Child Department, the Charge Nurse (or delegate) of the Hospital Nursery/NICU, the Charge Nurse (or delegate) of Hospital Pediatrics and representatives from Respiratory Therapy and Training and Education. The Chief of the Pediatric Service shall serve as Chairman of the Nursery/NICU/Pediatric Committee.

2) Duties

The duties of the Nursery/NICU/Pediatric Committee shall include:

a) establishing guidelines and standards of care in Nursery/NICU and Pediatrics;

b) providing ongoing continuing education programs for unit personnel and Physicians; and

c) reviewing neonatal deaths.

3) Meetings

The Nursery/NICU/Pediatric Committee shall meet as needed, but at least every other month. The Committee shall maintain minutes of its activities and report to the Medical Executive Committee and to the Departments affected by its actions.

P. Oncology Committee

1) Composition

The Oncology Committee is a multidisciplinary standing Committee and shall consist of the cancer liaison Physician and one (1) Board Certified Physician representative from Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology, and Pathology. The Administrator may recommend to the Committee Chairman non-physician membership, which must include personnel from Administration and the following Hospital departments: Nursing, Social Services, Cancer Registry, and Quality Assurance. The Chief of Staff or Chairman of the Oncology Committee shall appoint other Physician representatives as deemed necessary based on the cancer experience of the Hospital. It is expected that Physician representatives from the five (5) major sites of cancer seen in the Hospital will be included.

2) Duties

The duties of the Oncology Committee shall include:

a) developing and evaluating the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer;

b) promoting a coordinated, multidisciplinary approach to patient management;

c) ensuring that educational and consultative cancer conferences cover all major sites and related issues;

d) ensuring that an active supportive care system is in place for patients, families, and Staff;

e) monitoring quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes;

f) promoting clinical research;

g) supervising the Cancer Registry and ensuring accurate and timely abstracting, staging, and follow-up reporting;

h) performing quality control of registry data;

i) encouraging data usage and regular reporting;

j) ensuring that all American College of Surgeons Commission on Cancer standards are met;

k) disseminating the results of the annual cancer outcome studies; and

l) upholding medical ethical standards.

3) Meetings

The Oncology Committee shall meet at least quarterly. It shall maintain minutes of its proceedings and shall make reports of its activities and recommendations to the Medical Executive Committee.

Q. Operating Room Committee

1) Composition

The Operating Room Committee shall consist of the Chairman of the Department of Surgery, serving as Committee Chairman, and the following nine (9) additional members:

a) a representative from the Anesthesiology Service;

b) a representative from the General Surgery Service;

c) a representative from the Orthopedic and Neurological Surgery Services;

d) a representative from the Obstetrics and Gynecology Service;

e) a representative from the Urology, Otolaryngology Services;

f) a representative from the Ophthalmology and Plastic Surgery Services;

g) a representative elected at-large from the Medical Staff by the Department of Surgery;

h) a representative of the Administration; and

i) the Operating Room Director and Hospital personnel as requested by the Committee Chairman.

The Representatives of the Administration, the Operating Room Director and such other Hospital personnel serving as members are non-voting members of the Committee. Each member shall serve on the Operating Room Committee for a term of two (2) years.

2) Duties

Duties of the Operating Room Committee shall include:

a) administering Operating Room Guidelines adopted by members of the Department of Surgery;

b) coordinating multi-specialty needs for utilization of Operating Room resources;

c) evaluating utilization of the Operating Room personnel;

d) reporting patient care trends to the Quality Management Committee;

e) when requested, reviewing the trends of the practice of surgery in the Hospital Operating Rooms; and

f) making recommendations on equipment and physical improvements.

3) Meetings, Reports, Recommendations

a) The Operating Room Committee shall meet every other month. Additional meetings may be called at the discretion of the Committee Chairman.

b) Minutes of the meetings shall be prepared.

c) All recommendations from the Operating Room Committee shall be delivered to the Department of Surgery to be acted upon by the Chairman of the Department of Surgery.

R. Pharmacy and Therapeutics Committee

1) Composition

The Pharmacy and Therapeutics Committee shall consist of at least five (5) representatives from the Staff, non-voting representatives from the Hospital Pharmacy Service, the Hospital Nursing Service and Administration.

2) Duties

The duties of the Pharmacy and Therapeutics Committee shall include:

a) assisting in the formulation of professional practices, policies, and criteria regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital, in order that the quality of medical care provided in the Hospital may be improved;

b) advising the Staff and the Hospital Pharmaceutical Service on matters pertaining to the choice of available drugs;

c) making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

d) periodically developing and reviewing a formulary or drug list for use in the Hospital;

e) evaluating clinical data concerning new drugs or preparations requested for use in the Hospital;

f) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

g) reviewing drug reactions;

h) reviewing and approving a manual of policies and procedures for the Pharmaceutical Service in the Hospital to be drafted by the registered pharmacist; and

i) appointing a Formulary Committee and receiving reports from such Committee.

3) Meetings

The Committee shall meet as often as necessary at the call of its Chairman, but at least quarterly. It shall maintain minutes of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

S. Physician Resource Development Committee

The Physician Resource Development Committee shall be composed of at least six (6) members appointed from the Medical Staff by the Chief of Staff. The Committee's duties shall include making recommendations regarding periodic updating of the Medical Staff Development Plan and Policy guidelines for the formal recruitment of additional physicians for the Hospital and community by the Hospital Authority. The Committee shall operate under guidelines approved by the Medical Executive Committee. The Committee's recommendations shall be considered by the Executive

Committee, which will forward such recommendations to the Administration or Board, as appropriate.

T. Quality Management Committee

1) Composition

The Quality Management Committee will consist of two (2) divisions: Medicine; and Surgery. The composition will include the Chairman and Vice-Chairman of the Department of Medicine, the Chairman and Vice-Chairman of the Department of Surgery, plus members representing each Service and Section of the Department of Medicine and the Department of Surgery. Appointments from the Department of Medicine and Department of Surgery will be made by the Chief of Staff. Meetings will be attended by the Medical Director (ex-officio), representatives from Hospital Quality Assessment and Risk Management personnel, and by any other Staff Members needed by the Divisions of the Committee to discuss assigned cases for review.

2) Responsibilities

The Medicine Division and the Surgery Division of the Committee will annually meet jointly and as needed to make recommendations upon and approve the Performance Improvement/Patient Safety Plan and will consider other issues of Quality Management as needed with the Chief of Staff to act as Chairman of this combined meeting.

3) Duties

The Quality Management Committee's primary duty is to measure, assess and improve Practitioners' performance. The method for implementing this duty and others are further defined in Medical Staff Policy, MS # 1, *Medical Staff Review of Practitioners' Performance,* as amended from time to time pursuant to these Bylaws, (the "Medical Staff Review Policy") and include the following:

a) The Medicine and Surgery Divisions will meet separately bimonthly and as needed with the Chairman of the respective Department serving as Chairman. In the absence of the Chairman, the Vice-Chairman may serve.

b) Responsibilities of each Division include reviewing cases which are reviewable by requirement of the Performance Improvement/Patient Safety Plan, regulatory agencies, and accreditation organizations, Medical Staff Review Policy, and other cases assigned by the Chairman of the Division or the Chief Medical Officer, or delegated for review by the Committee pursuant to the Bylaws or Staff Rule, Regulation or Policy.

Such cases include, where applicable, review of medical records for clinical pertinence. The Chairman of the Division may, in his or her discretion, present such peer review cases directly to the Medical Executive Committee for additional review pursuant to the Medical Staff Review Policy.

c) Each division will monitor performance, safety, effectiveness and outcomes by Department, Service, Section and individual provider with Clinical Privileges and/or Clinical Functions. The divisions will review surgical and other invasive procedures to improve the selection (appropriateness) and performance (effectiveness) of the procedures.

d) Divisions will review reports of specimens removed during procedures for major discrepancy or pattern of discrepancies, between preoperative and postoperative (including pathologic) diagnoses. The divisions will review usage and ordering practice of all blood and blood products, all confirmed transfusion reactions, and the adequacy of the transfusion service to meet the needs of patients. The divisions will review the efficiency, appropriateness, timeliness, safety and effectiveness of the procedure, treatment or tests to determine its relevance to the patient's clinical needs.

e) Priority will be given to diseases and/or procedures that are of high risk or are performed in high volume.

f) The findings, conclusions, recommendations of and actions taken by the Quality Management Committee will be maintained and submitted to the Medical Executive Committee detailing Departmental analysis of patient care.

4) Assistance of Medical Officer and Accreditation/Process Improvement Staff

The Accreditation/Process Improvement Department staff and the Medical Officer assist the Committee in furtherance of its activities necessary to measure, assess, and improve performance by the Medical Staff, including the activities described in the Medical Staff Review Policy.

5) Committee Action Not Required for Corrective Action

Action or consideration by the Quality Management Committee is not required, and neither this Article X, T., nor the Medical Staff Review Policy, establish, procedures which must be followed prior to a Division Chairman presenting case(s) to the Medical Executive Committee or the initiation of corrective action proceedings pursuant to the Medical Staff Bylaws.

In the event that a Division Chairman, at any time during the evaluation and review processes described above, determines that a Practitioner's performance at issue is such that corrective action might be warranted pursuant to the Medical Staff Bylaws, the Division Chairman may, in his/her discretion, present the

performance issues to the Medical Executive Committee for consideration and further action.

If the Committee determines that a Practitioner's performance warrants investigation by the Medical Executive Committee to determine whether corrective action against the Practitioner is warranted, the Committee will direct the Division Chairman to request such initiation of investigation pursuant to the Medical Staff Bylaws.

6) Confidentiality

All proceedings involving Practitioners must be held in the strictest confidence and shall not be discussed or disseminated outside the proceedings of the Quality Management Committee, except as provided in these Bylaws and as required by law. Any breach of this confidentiality by Committee members or members of the Staff will be considered grounds itself for disciplinary action. The Quality Management Committee's activities and functions, including activities of persons acting at the Committee's direction and request, constitute peer review and medical review activities and are entitled to protection afforded by Georgia peer review and medical review privileges.

U. Utilization Review Committee

1) Composition

The Utilization Review Committee shall be appointed by the Chief of Staff from among the Staff Members and may also include non-member consultants and representatives of relevant Hospital services, appointed by the Chief of Staff and the Administrator, which consultants and representatives shall not be eligible to vote.

2) Duties

The duties of the Utilization Review Committee shall include:

a) conducting utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, use of medical and Hospital services, and all related factors which may contribute to the effective utilization of Hospital and Staff services;

b) studying patterns of care and maintaining criteria relating to patterns of care;

c) maintaining criteria relating to usual lengths of stay by specific disease categories, and evaluating systems of utilization review employing such criteria;

d) working toward the assurance of proper continuity of care upon discharge through the accumulation of data on the availability of other suitable healthcare facilities and services outside the Hospital;

e) communicating the results of its studies and other pertinent data to the Medical Executive Committee and making recommendations for the optimum

utilization of resources and facilities commensurate with quality patient care and safety;

f) formulating a written utilization review plan and submitting such plan to the Medical Executive Committee for approval;

g) evaluating the medical necessity of continued in-hospital services for particular patients, when appropriate;

h) conducting monthly reviews of all claim denials submitted by Staff Members from outside peer review organizations, which they feel are medically unsound; and

i) notifying Staff Members regarding matters of utilization, denial of claims and comparative data as needed.

3) Meetings

The Utilization Review Committee shall meet quarterly and as needed. The Committee shall maintain minutes of its findings, proceedings, and actions and shall make a quarterly report to the Medical Executive Committee.

V. Neuro Care Team

1) Composition

The Neuro Care Team shall consist of the members of the Neurology Service, the Emergency Department Director or designee, and neurology nurse practitioners and physician assistants appointed by the Chief of Staff. The Chief of Staff shall appoint one of the Active Staff Committee members to serve as Chairman of the Committee. The Chairman of the Committee may appoint clinical administrators to attend all or portions of meetings as needed. Voting shall be limited to Active Staff Members.

2) Duties

The duties of the Neuro Care Team shall include:

a) evaluating the overall quality of neurology services provided in the Hospital;

b) making recommendations regarding the neurology services provided in the Hospital;

c) reviewing incidents related to neurology services offered at the Hospital;

d) serving as a liaison between physicians, nurses, and other personnel providing neurology services and the Medical Staff and the Administration;

e) periodically, but not less than annually, reviewing the policies and procedures relating to the provision of neurology services in the Hospital, including Emergency Department policies and protocols; and

f) overseeing the performance of the medical director(s) supervising the provision of neurology services at the Hospital.

3) Meetings

The Neuro Care Team shall meet as needed, but not less often than quarterly.

4) Reporting

The Committee shall maintain minutes of its activities and report all activities and recommendations to the Medical Executive Committee.

W. Trauma Committee

1) Composition

The Chief of Staff appoints the Chairman of the Trauma Committee who shall be a surgeon with trauma training. The Trauma Committee shall consist of: The Chief of General Surgery; Chief of Emergency Medicine; Chief of Orthopedics; Chief of Neurosurgery; the Chief of Cardiothoracic Surgery; the Chief of Critical Care Medicine; the Laboratory Medical Director; Chairman of the Department of Medicine; and the Chairman of Department of Surgery. Notwithstanding the designated individuals identified herein, the committee shall maintain three (3) Active Staff Members who maintain Clinical Privileges appointed by the Chairman of the Committee from the Department of Medicine; and not less than three (3) Active Staff Members who maintain surgical Clinical Privileges appointed by the Chairman of the Committee which members may be the individuals identified above. In addition, the Chief Medical Officer (ex-officio, non-voting) shall also participate on the Committee.

2) Duties

The duties of the Trauma Committee shall include:

a) Evaluating the overall quality of the trauma services provided in Hospital and making recommendations for improvement by:

i. Participation in the American College of Surgeons reporting for designation by the State of Georgia Trauma Commission;

ii. Review of the Hospital's prompt assessment, resuscitation, emergency operations, and stabilization and also arrange for

transfer to a facility that can provide definitive trauma care when needed;

iii. Evaluate the Hospital's trauma center scorecard and any applicable quality metrics established by the Trauma Committee with comparison of accepted quality markers to national and regional benchmarks;

iv. Review of publicly reported metrics by the American College of Surgeons related to trauma center designation, as applicable;

v. Participation in the Georgia Trauma Commission with comparison of accepted quality markers to national and regional benchmarks;

vi. Evaluate Hospital's staffing to ensure continuous (a) general surgical coverage; and (b) coverage in the specialties necessary to satisfy the State trauma designation applied to the Hospital, including ensuring a surgeon is present in the emergency department on patient arrival, subject to adequate notification from the field;

vii. Review and recommend proper training to ensure providers providing care in the emergency department maintain advanced trauma life support certification and applicable continuing medical education requirements to satisfy the American College of Surgeons and the Georgia Trauma Commission requirements for the Hospital's applicable trauma designation; and

viii. Participate in regional and statement trauma system meetings and committees that provide oversight.

b) Developing and participating in a comprehensive quality assessment program to evaluate patient outcomes and best practices.

c) Develop and participate in trauma prevention and continuing education programs for the staff and provide community outreach and educational programs.

3) Meetings

The Trauma Committee shall meet as needed and not less often than quarterly. A quorum is defined as 33 ½% of eligible voting members.

4) Reporting

The Trauma Committee shall maintain minutes of its activities and report all activities and recommendations to the Medical Executive Committee.

X. Breast Program Leadership Committee

1) Composition

The Breast Program Leadership Committee is a multidisciplinary standing Committee and shall consist of the Breast Program Director and one (1) Board Certified Physician representative from Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology, and Pathology. The Administrator may recommend to the Breast Program Director/Chairman non-physician membership, which includes personnel from Administration and the following Hospital departments: Reconstruction, Research, Nursing, Social Work, Cancer Registry, and Quality Assurance. The Breast Program Director/Chairman of the Breast Program Leadership Committee shall appoint other Physician representatives as deemed necessary based on the breast cancer experience of the Hospital.

2) Duties

The duties of the Breast Program Leadership Committee shall include:

a. Developing and evaluating the annual goals and objectives for the clinical, educational, and programmatic activities related to breast cancer;
b. Promoting and coordinating multidisciplinary approach to patient management;
c. Ensuring that educational and consultative cancer conferences cover all required components related to breast cancer diagnosis and treatment;
d. Ensuring that an active support care system is in place for patients, families, and Staff;
e. Monitoring quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes;
f. Promoting clinical research;
g. Supervising the Cancer Registry and ensuring accurate and timely abstracting, staging, and follow-up reporting;
h. Performing quality control of registry data;
i. Encouraging data usage and regular reporting;
j. Ensuring that all American College of Surgeons National Accreditation Program for Breast Centers standards are met;
k. Upholding medical ethical standards

3) Meetings

The Breast Program Leadership Committee shall meet at least quarterly.

4) Reporting

The Breast Program Leadership Committee shall maintain minutes of its activities and report all activities and recommendations to the Medical Executive Committee.

Y. Assistance from Medical Director

In the event there is a Medical Director in office, any Committee of the Staff may utilize the assistance of the Medical Director in performing any of its duties.

ARTICLE XI - CORRECTIVE ACTION

A. Procedures and Conduct

1) Conduct

Activities or professional conduct of any Practitioner which affects or could affect adversely the health or welfare of patients or the delivery of quality patient care, or conduct lower than the accepted standards or aims of the Staff, or behavior disruptive to the operation of the Hospital, or conduct in violation of or contrary to these Bylaws, the Rules and Regulations or Policies of the Staff, or the Bylaws or Rules and Regulations or Policies of the Hospital Authority, may be deemed appropriate for corrective action.

2) Request for Initiation of Investigation

Any Officer of the Staff, the Chairman of any Department, the Chief of any Service, the Chairman of any standing Committee, the Administrator, the Medical Director or the Board may request the Medical Executive Committee to investigate the activities or conduct of a Practitioner to determine whether corrective action against the Practitioner is warranted. All requests for investigation shall be submitted to the Medical Executive Committee in writing and supported by reference to the activities or conduct constituting grounds for the request. The Chairman of the Medical Executive Committee shall promptly notify the Administrator in writing of all requests for investigation received by the Medical Executive Committee and shall continue to keep the Administrator fully informed of all action taken in connection therewith.

3) Medical Executive Committee Investigation

a) When a request for initiation of investigation is submitted to the Medical Executive Committee, the Medical Executive Committee shall determine whether the request contains enough information to warrant an investigation. The Medical Executive Committee may elect to discuss the matter with the Practitioner concerned, or to begin an investigation.

b) An investigation shall begin only after the Medical Executive Committee adopts a formal resolution to that effect. After resolving to initiate an investigation, the Medical Executive Committee shall within five (5) business days notify the Practitioner of the initiation of the investigation in writing by certified mail, return receipt requested.

c) The Medical Executive Committee shall meet as soon as possible after resolving to initiate an investigation to determine if the request for

investigation presented contains sufficient information to warrant a recommendation. If the request presented does not contain sufficient information for the Medical Executive Committee to make a recommendation, the Medical Executive Committee may investigate the matter or appoint a Special Professional Review Committee ("Review Committee"). If a Review Committee is utilized, the scope of the review by the Review Committee shall be specified in a written protocol from the Medical Executive Committee. The Review Committee composition shall be specified in the protocol. The Review Committee shall be composed of at least three (3) persons, who may or may not be members of the Staff, and who are not in direct economic competition with the Practitioner. If the members of the Review Committee determine they lack the expertise to adequately review a Practitioner's practice, the Review Committee shall seek assistance from other Staff Member(s) with such expertise, if any. When in the judgment of the Review Committee or the Medical Executive Committee, there are no Staff Members with such expertise who are willing to meaningfully participate in the review or the participation of such Staff Members may give rise to an irreconcilable conflict of interest, or an independent review would be most effective, the Review Committee shall utilize an independent review procedure. The selection of the external reviewer shall be approved by the Administrator or his or her designee. The timeline for the review shall be specified within the protocol, but ordinarily the review process should be completed within sixty (60) days of the formation of the Review Committee unless external review is used. If external peer review is used, an additional sixty (60) days is anticipated. The Review Committee shall report its findings and recommendations to the Medical Executive Committee. Confidentiality shall be maintained consistent with these Bylaws.

4) Medical Executive Committee Action

a) If a Review Committee is utilized, the Medical Executive Committee shall, within thirty (30) calendar days of receipt of the recommendation of the Review Committee, accept, modify or reject such recommendation.

b) The Medical Executive Committee may make a recommendation with or without a personal interview with the Practitioner. If the Practitioner is requested to appear before the Medical Executive Committee or a portion thereof, such appearance shall not constitute a hearing, but shall be a preliminary interview investigative in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. Legal counsel shall not be allowed to be present at such investigative interview, and no verbatim or detailed record of the substance of such interview shall be prepared.

c) The Medical Executive Committee may take one (1) of the following actions: determine that no action is justified; issue a warning, a letter of admonition or a letter of reprimand; impose terms of probation;

impose a requirement for consultation or continuing medical education; recommend that an already imposed summary suspension of Clinical Privileges be terminated, modified or sustained; recommend a reduction, suspension or revocation of Clinical Privileges; recommend alteration of already imposed restrictions; recommend suspension or revocation of Staff Membership; or make such other recommendation(s) as it deems necessary or appropriate. Action so taken may form the basis of future actions.

d) A written record of action taken on the request for investigation shall be made by the Medical Executive Committee and kept on file at the Hospital. The Medical Executive Committee shall promptly notify the Administrator of its action made in response to a request for investigation.

e) If the action of the Medical Executive Committee is not adverse to the Practitioner, as defined in Article XII, A.(3) of these Bylaws, the recommendation shall take effect immediately without a hearing, without action by the Hospital Authority and without the right to an appeal to the Hospital Authority. A report of the action taken, and the reasons for such action, shall be made to the Hospital Authority and the action shall stand unless modified by the Hospital Authority. If the Hospital Authority determines to consider modification of the action of the Medical Executive Committee and such modification would entitle the Practitioner to a hearing in accordance with these Bylaws, it shall so notify the Practitioner and the Practitioner shall be afforded the opportunity to exercise the right to a hearing and appeal as provided in these Bylaws.

f) If any action or recommendation of the Medical Executive Committee is adverse to the Practitioner, as defined in Article XII, A.(3) of these Bylaws, the Administrator shall, within ten (10) days after the Medical Executive Committee's decision, notify the Practitioner in writing by registered mail, certified mail, or by personal service, of the professional review action proposed or recommended to be taken against the Practitioner and the reasons for the proposed action. The notice shall further advise the Practitioner of his or her right to request a hearing pursuant to Article XII; include a copy of Article XII of these Bylaws; specify that the Practitioner shall have thirty (30) days following the date of his or her receipt of the notice within which to request a hearing; state that the failure to request a hearing within the specified time period shall constitute a waiver of Practitioner's right to the same; state that after receipt of his or her request, Practitioner will be notified of the date, time and place for the hearing, which date shall not be less than thirty (30) days after the notice scheduling the hearing. The notice shall further advise the Practitioner of his or her right: to representation by a lawyer or other person of Practitioner's choice; to have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of reasonable charges; to call, examine and cross-examine witnesses; to present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law; and to submit a written

statement on his or her behalf at the close of the hearing. In the event that the Practitioner is entitled to, and requests such a hearing, the procedures set forth in Article XII shall be followed.

B. Confidentiality

All proceedings involving Practitioners must be held in the strictest confidence and shall not be discussed or disseminated outside the proceedings provided in Articles XI and XII, except as required by law. Any breach of this confidentiality by Committee members or members of the Staff will be considered grounds itself for disciplinary action. Practitioners are urged not to inquire into ongoing proceedings. The Board will also cause the Administrator to maintain such portions of the proceedings as may come to his or her attention in strictest confidence.

C. Precautionary Suspension or Restriction

1) Circumstances

The Board, the Medical Executive Committee, or in consultation with the Chairman of the respective Department, if such Chairman is immediately available, any two (2) of the following: Chief of Staff, the Administrator, or the Medical Director, shall have the authority to suspend or restrict all or any portion of the Clinical Privileges of a Practitioner, effective upon imposition, whenever it is reasonably believed that failure to take such action may result in imminent danger to the health of any individual. Some examples of such circumstances include, but are not limited to, the following:

a) the Practitioner's temporary or permanent mental or physical state is such that one or more patients under his or her care would be subject to imminent danger to their health as a result of his or her action or inaction if he or she is permitted to exercise Privileges; or

b) there is substantial evidence of a gross dereliction of duty which relates to the assurance of a patient's well-being, or in the management of a patient, which, in the judgment of those having authority to act, indicates one or more patients under the present and/or future care of the Practitioner involved would be subject to imminent danger to their health if he or she is permitted to continue to exercise Privileges; or

c) a pattern or unusually high frequencies of unexpected deaths or morbidity shall constitute sufficient grounds to invoke this provision; or

d) non-compliance with an Agreement between the Practitioner and the Medical Executive Committee or the Hospital Authority, where the Agreement specifies non-compliance will result in suspension or the acts of non-compliance will place patient, staff or Practitioner welfare at significant risk.

Such suspension or restriction may also be imposed by the Board, the Medical Executive Committee or such persons listed above upon the recommendation of the Physician Support Committee.

Any precautionary suspension or restriction is an interim step in a professional review activity, but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction. The Practitioner may be given an opportunity to refrain voluntarily from exercising Clinical Privileges pending an investigation.

2) Notice

When precautionary suspension or restriction is imposed by persons other than the Chief of Staff, such persons shall immediately transmit notice of the precautionary suspension or restriction to the Chief of Staff and the Administrator. The Administrator shall notify the affected Practitioner in writing of the suspension or restriction, the grounds therefore and his or her right to a meeting with the Medical Executive Committee pursuant to Article XI, C.(3). This notice shall be delivered to the Practitioner in person within twenty-four (24) hours of the Administrator's receipt of notice of the suspension or restriction if practical; if not, then mailed by certified or registered mail within such time period.

3) Investigative Meeting

A Practitioner whose Clinical Privileges have been suspended or restricted pursuant to Article XI, C.(1) shall be entitled to request, at any time within ten (10) calendar days following receipt of notice of such suspension or restriction, that the Medical Executive Committee hold an investigative meeting not less than three (3) business days nor more than ten (10) calendar days after the Chairman of the Medical Executive Committee receives a written request for such a meeting. The purpose of this meeting shall be to review the matter resulting in a precautionary suspension or restriction and to determine whether an actual risk of imminent danger to the health of any individual exists so as to support the imposition of the suspension or restriction. The Chief of Staff shall set the date for the meeting in consultation with the affected Practitioner. The affected Practitioner may be present, but neither the Practitioner nor the Staff may be represented by legal counsel at this investigative meeting. No verbatim or detailed record of the meeting shall be prepared.

a) Medical Executive Committee Action

After considering the matters resulting in the suspension or restriction and the Practitioner's response, if any, the Medical Executive Committee shall determine whether there is sufficient information to warrant a final recommendation or whether it is necessary to commence an investigation. As a result of the meeting, the Medical Executive Committee may modify, continue or terminate the suspension or restriction, or recommend alternative corrective action.

b) Notice

Notice of action or recommendation adverse to the Practitioner, as defined in Article XII, A.(3), shall be given in accordance with Article XI, A.(4)(d) and (f).

c) Hearing

If the Medical Executive Committee does not terminate the suspension or restriction prior to the fourteenth (14^{th}) day of such suspension or restriction, the affected Practitioner shall be entitled to request a hearing in accordance with Article XII, but the terms of the suspension or restriction as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision thereon by the Hospital Authority. When the affected Practitioner requests a hearing, the procedures set forth in Article XII shall be followed.

4) Alternative Patient Care

Immediately upon the imposition of a precautionary suspension or restriction, the Chief of Staff shall assign to another Practitioner with appropriate Clinical Privileges responsibility for medical coverage of the suspended Practitioner's patient(s) still in the Hospital. The wishes of the patient(s) shall be solicited and taken into consideration, along with relevant medical factors, in the assignment of such alternative Practitioner.

5) Reporting of Suspension or Restriction to Licensing Board and NPDB

The Administrator shall report a precautionary suspension or restriction to the Georgia Composite Medical Board and the National Practitioner Databank ("NPDB"), as required under applicable law or regulation, as such laws and regulations are amended from time to time, and in compliance with then existing rules and directives of the NPDB. As of January 1, 2004, such reporting shall be made within fifteen (15) days of:

a) the Medical Executive Committee's recommendation to continue a suspension or restriction which is based on the professional competence or professional conduct of a Practitioner which adversely affects or could adversely affect the health or welfare of patients(s) and which is in effect or imposed for more than thirty (30) days; and

b) the Practitioner's surrender of his or her Clinical Privileges or Staff Membership during a suspension or restriction.

If the precautionary suspension or restriction is modified or revised as part of the final decision of the Board, the Administrator shall submit a Revision to Action of the Initial Report to the NPDB. Final adverse professional review actions are further reported as provided in Article XII, J.(3) of these Bylaws.

D. Automatic Relinquishment or Restriction

1) Licensure & State Board Action

Practitioners must be appropriately licensed to practice. The expiration without renewal of a Practitioner's professional license or action by the Georgia Composite Medical Board or other appropriate licensing board revoking or suspending a Practitioner's license shall result in the automatic relinquishment of the Practitioner's Staff Membership and Clinical Privileges. The expiration without renewal of a Limited License Professional's license or action by the appropriate state licensing board revoking or suspending the license of a Limited License Professional exercising Clinical Privileges shall result in the automatic relinquishment of the Limited License Professional's Clinical Privileges. Such automatic relinquishment of Staff Membership and Clinical Privileges shall continue throughout the period during which the Practitioner's license is revoked or suspended or the Practitioner is not appropriately licensed to practice. In the absence of any corrective action which has adversely affected the Practitioner's Staff Membership or Clinical Privileges, the automatic relinquishment described in this Article XI, D.(1) shall automatically terminate upon the reinstatement or renewal of the Practitioner's license by the Georgia Composite Medical Board or other appropriate state licensing board.

2) State or Federal Drug Enforcement Administration Action

Action by the Drug Enforcement Administration (including voluntary relinquishment by the Practitioner under investigation) revoking or suspending a Practitioner's controlled substances registration shall result in the automatic relinquishment or restriction of the Practitioner's Staff Membership and Clinical Privileges to the extent necessary to be consistent with the action taken by the Drug Enforcement Administration. Action by the Drug Enforcement Administration revoking or suspending the controlled substances registration of a Limited License Professional exercising Clinical Privileges shall result in the automatic relinquishment or restriction of the Limited License Professional's Clinical Privileges to the extent consistent with the action taken by the Drug Enforcement Administration. In the absence of any corrective action which has adversely affected the Practitioner's Staff Membership or Clinical Privileges, the relinquishment or restriction described in this Paragraph shall automatically terminate upon the reinstatement of the Practitioner's registration by the Drug Enforcement Administration.

3) Failure to Maintain Required Insurance

A Practitioner's failure to maintain continuous professional liability insurance coverage in the amounts of One Million dollars ($1,000,000.00) per occurrence or

Three Million dollars ($3,000,000.00) in the aggregate or as required by these Bylaws or the Medical Staff Rules and Regulations or Governing Board direction shall be deemed a voluntary relinquishment of Practitioner's Clinical Privileges as of that date until the matter is resolved and adequate professional liability insurance coverage is restored. In the absence of any corrective action which has adversely affected the Practitioner's Staff Membership or Clinical Privileges, the relinquishment described in this Paragraph shall automatically terminate upon the reinstatement of the Practitioner's required professional liability insurance coverage.

4) Medical Records

a) An automatic relinquishment of a Practitioner's Clinical Privileges shall result after a warning of delinquency for failure to complete History and Physicals within twenty-four (24) hours of admission or to complete all medical records within twenty-one (21) days after the date of discharge. The Practitioner will be provided with a detailed listing weekly of all assigned incomplete records. The list will show the date of assignment to Practitioner.

b) A Practitioner with History and Physical Examinations incomplete after twenty-four (24) hours from admission or other medical records remaining incomplete for twenty-one (21) days after discharge of the patient will be notified in writing by the Administrator or his or her designee. The Administrator or his or her designee shall send copies of the notice to the Chairman of the Medical Records Committee, the Chief of Staff and the Chairman of the Practitioner's Department. The Practitioner shall have four (4) days from the date of the notice to complete History and Physicals and all other medical records incomplete over twenty-one (21) days identified in the weekly notice. If the medical records remain incomplete beyond the four (4) day period, the Administrator or his or her designee shall send the Practitioner a notice that his or her Clinical Privileges have been automatically relinquished. A copy of this notice is sent to the Chairman of the Medical Records Committee, the Chief of Staff, the Chairman of the Practitioner's Department, the Admissions Department and other Departments, if applicable. This automatic relinquishment of Clinical Privileges can be waived only by the Administrator, the Chairman of the Medical Records Committee, or the Chief of Staff acting on behalf of the Practitioner. The Practitioner's Privileges will be immediately reinstated when the Practitioner has completed History and Physicals over twenty-four (24) hours old and all the incomplete records over twenty-one (21) days in full. A copy of the reinstatement notice will be sent to all parties previously notified of the automatic relinquishment.

c) A Practitioner remaining delinquent in excess of thirty-two (32) days past the date of the automatic relinquishment of the Practitioner's Clinical Privileges shall result in automatic relinquishment of his or her Staff Membership or Limited License Professional Membership and all

Clinical Privileges and the Practitioner shall be required to pay $100.00 per record and reapply for Medical Staff Membership or Limited License Professional Membership and Clinical Privileges by submission of an application to the Administrator or his or her designee. Any exception will be submitted to the Medical Executive Committee for individual consideration. The Administrator or his or her designee will be required to notify the delinquent Practitioner by certified mail at least twenty-four (24) hours prior to the Practitioner's automatic relinquishment of his or her Staff Membership of Limited Licensed Professional status, as applicable, and all Clinical Privileges.

d) Said fees shall be in addition to the usual fee for initial applications and shall accompany the application for re-instatement of Clinical Privileges.

5) Notice

The Chief of Staff shall promptly transmit notice of any automatic relinquishment based on failure to complete medical records as described in Article XI, D.(4) and (5) above to the Administrator, who shall promptly notify the affected Practitioner in writing of the automatic relinquishment and the grounds therefore and notice of his or her rights, if any, under Article XII in the form prescribed in Article XI, A. (4). This notice shall be delivered to the Practitioner in person, if practical; if not, then by certified or registered mail. The Administrator shall likewise transmit notice of any automatic relinquishment or restriction under Article XI, D.(1), (2) or (3).

6) Enforcement

It shall be the duty of the Chief of Staff and the Medical Executive Committee to cooperate with the Administrator in enforcing all automatic relinquishments.

ARTICLE XII - FAIR HEARING PLAN AND APPELLATE REVIEW PROCEDURE

A. Grounds for Hearing

1) When any Practitioner receives notice of a recommendation of the Medical Executive Committee that if not appealed to the Hospital Authority will adversely affect the Practitioner's appointment to or status as a member of the Staff or exercise of Clinical Privileges, the Practitioner shall be entitled to request a hearing in compliance with this Article XII.

2) When a Practitioner receives notice of a decision by the Hospital Authority that if not appealed will adversely affect his or her appointment to or status as a member of the Staff or exercise of Clinical Privileges, and such decision is not based on a prior adverse recommendation by the Medical Executive Committee with respect to which the Practitioner was entitled to a hearing and appellate review, the Practitioner shall be entitled to a hearing as

provided herein, before the Hospital Authority makes a final decision on the matter.

3) The following recommendations or actions shall be deemed adverse if such recommendations or actions are based on the Practitioner's competence or professional conduct**,** which conduct affects or could adversely affect the health or welfare of a patient or patients and which affects, or could affect, adversely the Practitioner's Clinical Privileges or Staff Membership:

a) denial of initial Staff appointment or reappointment;

b) denial of requested advancement in Staff category;

c) reduction of admitting Prerogatives;

d) revocation of Staff appointment;

e) denial of requested initial Clinical Privileges or failure to renew Clinical Privileges;

f) denial of requested increased Clinical Privileges;

g) reduction or restriction of Clinical Privileges for a term of fourteen (14) days or more;

h) suspension of Staff Membership or Clinical Privileges for a term of fourteen (14) days or more (except in cases of Automatic Relinquishment or Restriction as provided in Article XI, D.;

i) non-reinstatement of requested Staff Membership or Clinical Privileges following a leave of absence; and

j) imposition of mandatory concurring consultation requirement.

4) No other recommendations except those enumerated above in Article XII, A.(3) shall entitle a Practitioner to request a hearing. For example, neither voluntary relinquishment of Clinical Privileges, nor the imposition of a requirement for retraining, additional training or continuing education, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

5) All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article. The Administrator shall assist the Medical Executive Committee in ensuring compliance with these procedural safeguards, with the support of the attorney who serves as general counsel to the Hospital Authority.

B. Request for Hearing

1) Notice of Adverse Decision

Within ten (10) days of the recommendation or decision, the Administrator shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected Practitioner who is entitled to a hearing. The notice shall clearly state the reasons for said adverse recommendation or decision, and shall be given in the form prescribed by Article XI, A.(4)(f).

2) Request

The Practitioner may request a hearing, in writing, by registered mail, certified mail, or by personal delivery to the Administrator, within thirty (30) days of his or her receipt of written notice of the adverse recommendation or decision.

3) Waiver of Right to Hearing and Appellate Review

The failure of a Practitioner to request a hearing to which he or she is entitled by these Bylaws within thirty (30) days of his or her receipt of written notice of the adverse recommendation or decision, shall be deemed a waiver of right to such hearing and to any appellate review to which he or she might otherwise have been entitled. The failure of the Practitioner to appear at the hearing requested, without good cause, shall be deemed a waiver of right to such hearing and to any appellate review to which he or she might otherwise have been entitled. The failure of a Practitioner to request an appellate review to which he or she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his or her right to such appellate review.

4) Effect of Waiver

When the waived hearing relates to an adverse recommendation of the Medical Executive Committee, the same shall thereupon become and remain effective against the Practitioner pending the Hospital Authority's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Hospital Authority, the same shall thereupon become and remain effective against the Practitioner in the same manner as a final decision of the Hospital Authority provided for in Article XII, J. In either of such events, the Administrator shall, within ten (10) days of such waiver, notify the affected Practitioner of his or her status by registered mail, certified mail, or by personal service.

C. Notice of Hearing

1) Scheduling of Hearing

The Administrator shall schedule and arrange for a hearing properly requested by the Practitioner pursuant to these Bylaws, and shall notify the Practitioner of the time, place and date so scheduled by registered mail, certified mail, or personal

service. The hearing date shall not be less than thirty (30) days from the date of the Practitioner's receipt of the notice of hearing unless the Hearing Panel and the Practitioner mutually agree that the hearing be held sooner. A hearing for a Practitioner who is under suspension shall be scheduled to begin as soon as arrangements therefore may reasonably be made, but in no event later than thirty-five (35) days from the date of receipt of the request for hearing.

2) Contents of Notice

The notice of hearing shall state:

a) the date, time and place of the hearing;

b) a list of names and addresses of witnesses (if any) expected to be called to testify at the hearing on behalf of the Medical Executive Committee or the Hospital Authority, as applicable, and a brief summary of the nature of the anticipated testimony of each witness; and

c) that the Practitioner, must within ten (10) days after receiving notice of the hearing, provide a written list of the names of the individuals expected to testify on the Practitioner's behalf and a brief summary of the nature of the anticipated testimony of each witness and that failure to provide such information will be grounds for the Presiding Officer to refuse the testimony of individuals who are not identified.

D. Hearing Panel

1) If a hearing is properly requested by the Practitioner pursuant to Article XII, B.:

a) When a hearing relates to an adverse recommendation of the Medical Executive Committee, the hearing shall be held before one (1) of the following as determined by the Administrator, acting on behalf of the Hospital Authority (collectively referred to hereinbefore and hereinafter as the "Hearing Panel"):

i) an arbitrator mutually acceptable to the Practitioner and the Administrator, acting on behalf of the Hospital Authority;

ii) a hearing officer who is appointed by the Administrator, acting on behalf of the Hospital Authority; or

iii) a panel of not less than three (3) individuals appointed by the Administrator, acting on behalf of the Hospital Authority.

b) When the hearing relates to an adverse decision of the Hospital Authority that is contrary to a favorable recommendation of the Medical Executive Committee, the Administrator, acting on behalf of the Hospital Authority, shall appoint a panel of not less than three (3) individuals. At

least one-third (1/3) of the panel shall be comprised of individuals approved by the Medical Executive Committee.

c) The Hearing Panel shall not include any individual who is in direct economic competition with the Practitioner, or who has acted as accuser, investigator, fact finder or initial decision maker in the matter. Neither knowledge of the matter involved nor the fact that a person holds a contract with the Hospital Authority shall preclude any individual from serving on the Hearing Panel. One of the persons appointed shall be designated as the Hearing Panel Chairperson.

d) The Administrator shall provide written notice to the Practitioner of the appointment of the Hearing Panel and the Practitioner's right to challenge the appointment within ten (10) days of his or her receipt of the notification.

E. Presiding Officer

1) The Administrator, acting on behalf of the Hospital Authority, shall appoint an attorney-at-law or the Hearing Panel Chairperson to serve as Presiding Officer. The Administrator shall provide written notice to the Practitioner of the appointment of the Presiding Officer and the Practitioner's right to challenge the appointment in writing within ten (10) days of his or her receipt of such notice.

2) If the Hearing Panel Chairperson is not appointed, the individual appointed as Presiding Officer may not concurrently represent any other involved party and shall be unbiased, experienced in hospital/medical staff relations, and shall be appropriately qualified to preside over the hearing. The Hospital Authority shall be responsible for compensating the Presiding Officer as is appropriate. Aside from such compensation for services, the Presiding Officer shall gain no direct financial benefit from the outcome, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote. However, the Presiding Officer is not prohibited from advising the Hearing Panel on issues related to hearing procedures, explaining any aspect of the hearing to the Hearing Panel, participating in the private deliberations of the Hearing Panel, or preparing the Hearing Panel report.

3) If the Hearing Panel Chairperson is appointed to perform the functions of Presiding Officer, he or she shall be entitled to one (1) vote as a member of the Hearing Panel and shall perform the obligations of Presiding Officer as set forth in Article XII, E.(5) below.

4) The Presiding Officer may be advised by legal counsel to the Hospital Authority.

5) The Presiding Officer shall:

a) determine the order of hearing procedure;

b) act to maintain decorum in the hearing;

c) act to ensure that all participants in the hearing have a reasonable opportunity to present relevant evidence, subject to reasonable limits on the number of witnesses and duration of testimony and duration of cross-examination, as may be deemed necessary by the Presiding Officer, to avoid irrelevant or cumulative evidence or to prevent abuse of the hearing process; and

d) make rulings on all pre-hearing requests for inspection, copying and other access to evidence and issues pertaining to admissibility of evidence and matters of hearing procedure.

F. Pre-Hearing Procedure

1) Witnesses

a) Within ten (10) days after receiving notice of the hearing, the Practitioner shall provide a written list of the names and addresses of the individuals expected to offer testimony or present evidence on the Practitioner's behalf and a brief summary of the nature of the anticipated testimony of each witness. Failure to do so will be grounds for the Presiding Officer to refuse testimony from these individuals who are not identified.

b) The Presiding Officer may (but is not required to) allow the amendment of any party's witness list at any time during the hearing, provided that notice of the change is given to the other party and the Presiding Officer, in his or her sole discretion, determines sufficient cause exists which excuses the failure of the amending party to comply with Article XII, C.(2) or F.(1)(a), as applicable.

c) Without the consent of the Administrator or if designated by the Board, counsel to the Hospital Authority, the Practitioner shall not, either directly or through his or her agents or representatives, contact any Hospital employee appearing on the witness list of the Medical Executive Committee or the Hospital Authority concerning the subject matter of the hearing.

2) Challenge to Appointment of Presiding Officer and Hearing Panel

The Practitioner shall have a reasonable opportunity to challenge the appointment of the Presiding Officer and the person or persons constituting the Hearing Panel by submitting a written statement to the Administrator. The Administrator shall rule on challenges concerning the Presiding Officer and the Hearing Panel not later than seven (7) business days prior to the scheduled date of the hearing by written response to the Practitioner. The Practitioner must prove that the person(s) challenged does/do not meet the qualifications for appointment pursuant

to these Bylaws. There shall be no hearing or personal appearance regarding these challenges.

3) Access to Evidence

a) Each party shall be entitled, upon specific written request or by a written stipulation signed by both parties, to require the other party's agreement that documents used or intended to be used as evidence at the hearing shall be maintained as confidential and not disclosed or used for any purpose outside the hearing. As soon as practicable after the hearing has been requested, either party may have access to documents in possession of the other party as follows:

i) Subject to applicable laws and regulations, the Practitioner shall have the right to inspect and copy at his or her own expense:

(1) redacted copies of relevant Committee or Department minutes;

(2) copies of, or reasonable access to, all patient medical records relied upon by the Medical Executive Committee or the Hospital Authority; and

(3) any other documents, including reports of experts relied upon by the Medical Executive Committee or any Special Review Committee or special investigative committee appointed by the Medical Executive Committee or the Hospital Authority.

ii) The Practitioner shall not have the right to Information or access to the records of or documents relating to other Practitioners.

iii) The Medical Executive Committee or the Hospital Authority, as appropriate, shall have the right, as soon as practicable after the hearing has been requested, to inspect and copy, at its own expense, any document or other evidence relevant to the subject matter of the hearing which the Practitioner has in his or her possession.

b) The Presiding Officer shall have the sole discretion to rule upon any pre-hearing request for inspection, copying, or other access to evidence.

4) Pre-Hearing Conference

A pre-hearing conference may be held by the Presiding Officer for the purpose of resolving procedural issues prior to the hearing. The Presiding Officer may require that:

a) prior to the pre-hearing conference, the parties conclude their production of or access to evidence as requested by the other party pursuant to Article XII, F.(3) above;

b) prior to the pre-hearing conference, the parties exchange copies of all documentary evidence intended to be tendered to the Hearing Panel during the hearing;

c) the parties submit a final list of all witnesses, a summary of the nature of the anticipated testimony of each witness and the approximate length of such testimony;

d) each party to conclude presentation of evidence within time limits established by the Presiding Officer; establish time limits for each party to present evidence;

e) the parties make all objections to documentary evidence, or witnesses, to the extent known at the time;

f) witnesses and documentary evidence not provided prior to the conclusion of the pre-hearing conference may be excluded from the hearing; and

g) evidence unrelated to the reasons for or in opposition to the adverse recommendation be excluded.

G. Conduct of Hearing

1) Presence of Practitioner

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 to appear for the hearing after notice of the hearing. If the Practitioner fails without good cause to appear and proceed at such hearing, the Practitioner shall be deemed to have waived his or her rights and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect. The question of good cause shall be within the sole discretion of the Presiding Officer.

2) Postponements

Postponements of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Presiding Officer on a showing of good cause, with such showing of good cause being within the sole discretion of the Presiding Officer.

3) Transcript of Hearing

An accurate transcript of the hearing shall be kept by a certified court reporter. The Practitioner shall have the right to obtain a copy of the transcript of the proceeding, upon payment of charges associated with the transcription and copies. The Medical Executive Committee and the Hospital Authority shall also have the right to obtain a copy of the transcript. The Hospital Authority's counsel shall be responsible for securing the services of the court reporter. Oral evidence shall be taken only on oath or affirmation. All other evidence presented during the hearing shall be maintained by Medical Staff Services.

4) Representation of Practitioner

The affected Practitioner shall be entitled to be represented by an attorney or other person of Practitioner's choice.

5) Determination of Procedure

The Medical Executive Committee or the Hospital Authority, depending on whose recommendation prompted the hearing, shall present evidence in support of the recommendation first, followed by presentation of evidence by the Practitioner. The Presiding Officer shall further determine the order of procedure during the hearing to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

6) Presentation of Evidence

The hearing need not be conducted strictly according to rules of law and evidence relating to the examination of witnesses or presentation of evidence. For example, hearsay evidence that has rational probative force and that is corroborated may constitute evidence. The parties may introduce evidence not previously considered, provided that the party has reasonably complied with pre-hearing procedures and requirements imposed by the Presiding Officer pursuant to these Bylaws. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objections in civil and criminal actions. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedures, or of fact, and such memoranda shall become part of the hearing record. The Hearing Panel may request additional documentary evidence, question witnesses or call and question additional witnesses not presented by either party.

7) Burden of Proof and Required Evidentiary Standard

The Medical Executive Committee or the Hospital Authority, whichever made the adverse recommendation prompting the hearing, bears the initial burden to present evidence in support of the adverse recommendation or decision. The Practitioner then has the burden to prove by a preponderance of the evidence that the recommendation is arbitrary, capricious, unreasonable, or not supported by the

evidence. For purposes of these Bylaws, a "preponderance of the evidence" means evidence which is of greater weight or is more convincing than the evidence which is offered in opposition to it.

8) Representation of Medical Executive Committee and Hospital Authority

The Medical Executive Committee, when its recommendation is the subject of the hearing, shall appoint a Staff Member (including members of the Medical Executive Committee) or an attorney to present the facts in support of the adverse recommendation and to examine witnesses and advise the Medical Executive Committee during deliberations. The Hospital Authority, when its decision is the subject of the hearing, shall appoint an attorney, who may be the attorney who serves as counsel to the Hospital Authority, to present the facts in support of the adverse decision and to examine witnesses and to advise the Hospital Authority during deliberations. Said person shall not be entitled to vote on the adoption of a recommendation. The Hospital Authority may also require that the attorney who serves as general counsel to the Hospital Authority be present. Each attorney presenting the facts on behalf of the Medical Executive Committee or the Hospital Authority shall be compensated by and subject to the approval of the Hospital Authority.

9) Rights of the Parties

The parties shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

a) to call and examine witnesses;

b) to introduce evidence;

c) to hear or otherwise observe all evidence offered in connection with such hearing;

d) to cross-examine any witness on any matter relevant to the issue of the hearing;

e) to submit a written statement at the close of the hearing;

f) to challenge the credibility or opinions of any witness; and

g) to rebut any evidence.

If the Practitioner does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

10) Recess and Conclusion

The Hearing Panel may, without notice, recess the hearing and reconvene the same for the convenience of the participants, for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of evidence or upon a finding by the Presiding Officer, after consultation with the Hearing Panel, that the remaining evidence or testimony will be cumulative in nature, the hearing shall be closed.

11) Deliberations

Upon the closing of the hearing, the Hearing Panel may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties for whom the hearing was convened. The Presiding Officer may participate in the deliberations of the Hearing Panel and offer advice, but unless the Presiding Officer is the Hearing Panel Chairperson, shall not be entitled to vote.

12) Report and Recommendations

Within ten (10) business days after final adjournment of the hearing, the Hearing Panel shall make a written report and recommendation with reasons and facts upon which the recommendation is based and shall forward the same together with the hearing record as soon as the hearing record is available and all other documentation to the Medical Executive Committee or to the Hospital Authority, whichever group's recommendation or proposed action prompted the hearing. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or decision of the Hospital Authority. The modification may include an increase or a decrease in the severity of the original adverse recommendation or decision. The hearing record shall mean the pleadings, rulings, correspondence and documentary evidence.

13) Confidentiality

All proceedings involving Practitioners must be held in the strictest confidence. Any breach of this confidentiality by member(s) of the Hearing Panel will be considered grounds itself for disciplinary action. Practitioners are urged not to inquire into ongoing proceedings. The Hospital Authority will also cause the Administration to maintain such portions of the proceedings as may come to its attention in strictest confidence.

H. Reconsideration by Medical Executive Committee or Hospital Authority

1) Recommendation or Decision

Within ten (10) days after receiving the report and recommendation of the Hearing Panel, the Medical Executive Committee or the Hospital Authority, whichever group's adverse recommendation(s) or decision(s) preceded the hearing, shall meet and consider said report and recommendation. The Medical Executive Committee or the Hospital Authority, as applicable, shall make its

recommendation or decision whether to accept, reject or modify the recommendation of the Hearing Panel, in whole or in part. The Medical Executive Committee or the Hospital Authority, as applicable, shall transmit its final recommendation along with the Hearing Panel's report and recommendation to the Administrator.

2) Notice to Practitioner

Within ten (10) days after receiving the recommendation or decision from the Medical Executive Committee or the Hospital Authority, the Administrator shall provide prompt written notice of the recommendation or decision made or adhered to after a hearing as above provided to the Practitioner. The notice shall include a copy of the written recommendation of the Hearing Panel and if the recommendation or decision is adverse to the Practitioner, as defined in Article XII, A.(3), and the Practitioner is entitled to an appellate review, the notice shall:

a) state the recommendation or decision and the basis of said adverse recommendation or decision;

b) advise the Practitioner of his or her right to an appellate review pursuant to Article XII, I.;

c) specify that the Practitioner shall have ten (10) days following the date of receipt of said notice within which to request an appellate review;

d) state that failure to request an appellate review within the specified time period shall constitute a waiver of the Practitioner's rights to the same;

e) state that upon receipt of the Practitioner's request, he or she will be notified of the date, time and place for the appellate review;

f) advise the Practitioner of his or her right to review the hearing record or to obtain a copy (at his or her cost) of the hearing record and/or transcript of the proceedings;

g) advise the Practitioner that he or she has the right to submit a written statement in his or her behalf as part of the appellate procedure; and

h) advise the Practitioner of his or her right to the assistance of legal counsel or other person of his or her choice in the preparation of said written statement.

I. Appeal

1) Request for Appellate Review

Within ten (10) days after receipt of a notice by a Practitioner of an adverse recommendation or decision made after a hearing as above provided, the Practitioner may, by written notice to the Hospital Authority delivered through the Administrator, request an appellate review by the Hospital Authority. Such notice shall include a statement of the reasons for appeal and the specific facts and circumstances justifying further review as provided in Article XII, I.(2). The Practitioner may also request that oral argument be permitted as part of the appellate review.

2) Grounds for Appeal

The grounds for appeal are limited to the following:

a) the recommendations or decisions were made arbitrarily, capriciously, or unreasonably and/or were not supported by the evidence; and

b) there was substantial failure to comply with these Bylaws or applicable Rules, Regulations or Policies of the Hospital Authority or Staff to the extent that Practitioner was denied due process and a fair hearing.

3) Waiver of Right to Appellate Review

If such appellate review is not requested during the time period and in the manner described in Article XII, I.(1), the Practitioner shall have waived the right to the same, and have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Article XII, B.(4).

4) Scheduling of Appellate Review

Within ten (10) business days after receipt of such notice or request for appellate review, the Hospital Authority shall schedule a date for such review, including a time and place for oral argument if such has been requested and granted, and shall, through the Administrator, notify the Practitioner in writing of the same.

5) Written Statements

The Practitioner may submit a written statement on his or her own behalf, in which his or her grounds for appeal shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Hospital Authority through the Administrator by personal service or by registered or certified mail, at least five (5) business days prior to the date set for such appellate review. A similar statement may be submitted by the Medical Executive Committee or by the Hearing Panel Chairman, and if submitted, the Administrator shall provide a copy thereof to the Practitioner at least three (3) business days prior to the date of such appellate review.

6) Review

The Hospital Authority shall act as an appellate body. In conducting its review, the Hospital Authority may utilize its general counsel and a special sub-committee of the Hospital Authority or any other committee or body of the Hospital Authority it deems appropriate to review the hearing record and the issues presented on appeal. Such person(s) shall then present the case to no less than a majority of the Hospital Authority. In addition to the hearing record, the Hospital Authority shall consider the written statements submitted for the purpose of determining whether the adverse recommendation or decision against the affected Practitioner should be upheld. If oral argument is requested and granted as part of the review procedure, or if the Hospital Authority invites the Practitioner to appear and make an oral statement and the Practitioner elects to make such a statement, the Practitioner shall be afforded the opportunity to appear and speak against the adverse recommendation or decision, and shall answer questions put to him or her by any member of the Hospital Authority. If oral argument is held, the affected Practitioner and the Medical Executive Committee shall have the same rights to be represented by counsel as in the hearing proceeding. Regardless of whether attorneys are used to present the positions of the parties, the Hospital Authority may require that the attorney who serves as general counsel to the Hospital Authority be present at any oral argument.

7) Consideration of New Matters

New or additional matters not raised during the original hearing or in the Hearing Panel report, nor otherwise reflected in the record, shall not be introduced at the appellate review except to show the Practitioner's present compliance or non-compliance with the Bylaws, Rules and Regulations or Policies of the Hospital Authority or Staff or with prior decisions of the Medical Executive Committee or Hospital Authority. The Hospital Authority shall, in its sole discretion, determine whether such new matters shall be accepted.

8) Standard of Review

The Hospital Authority, while conducting its appellate review, shall consider the following standards of review:

a) whether the recommendation is supported by any evidence;

b) whether the recommendation was made in furtherance of the quality of healthcare;

c) whether the Hearing Panel and other individuals and committees made a reasonable effort to ascertain the facts prior to formulating the recommendation; and

d) whether the recommendation was made after adequate notice and hearing procedures were afforded to the Practitioner or after such other procedures as were fair to the Practitioner under the circumstances.

9) Hospital Authority Action

The Hospital Authority may affirm, modify, or reverse the prior recommendation or decision, or in its discretion, refer the matter back to the Medical Executive Committee for further review and recommendation. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve specified issues.

10) Conclusion of Appellate Review

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Article XII, I. have been completed or waived.

J. Final Decision

1) Decision

Within ten (10) days after conclusion of its appellate review, the Hospital Authority shall make its final decision. The decision shall be in writing and include the basis for the decision. A copy of the decision shall be sent to the Medical Executive Committee and through the Administrator, to the affected Practitioner by certified mail, registered mail, or by personal delivery within ten (10) days from the decision. The decision shall be immediately effective and final, and shall not be subject to further hearing or appellate review; provided, however, that if the Hospital Authority's decision has the effect of changing the Medical Executive Committee's last recommendation, if any, the decision shall not be considered final and the Hospital Authority shall immediately refer the matter to the Joint Conference Committee for further review and recommendation. Within ten (10) business days of the referral of the Hospital Authority's decision, the Joint Conference Committee shall submit a written recommendation to the Hospital Authority. Within ten (10) business days following the Hospital Authority's receipt of the recommendation of the Joint Conference Committee or at the next meeting of the Hospital Authority, whichever comes first, the Hospital Authority shall review the Joint Conference Committee's recommendation and make its final decision in the matter.

2) Conclusiveness of Appellate Review

Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled by right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Medical Executive Committee or by the Hospital Authority.

3) Report to State Licensing Board and NPDB

The Administrator shall report to the NPDB, the Georgia Composite Medical Board and other appropriate licensing boards as required by applicable law or regulation, as such laws are amended from time to time. As of January 1, 2004, the Administrator shall make such reports as follows:

a) To the NPDB, the Georgia Composite Medical Board and other appropriate licensing boards, within fifteen (15) days from the date of the Hospital Authority's final decision on any action taken in the course of professional review activity which:

i) is based on the professional competence or professional conduct of a Staff Member which adversely affects or could adversely affect the health or welfare of patient(s); and

ii) adversely affects the Practitioner's Clinical Privileges or Staff Membership for longer than thirty (30) days.

b) To the Georgia Composite State Board of Medical Examiners or other appropriate licensing board, within twenty (20) working days following any final action on the restriction, denial or revocation of Clinical Privileges; and

c) To the NPDB, the Georgia Composite Board of Medical Examiners and other appropriate licensing boards, within fifteen (15) days following the surrender of Clinical Privileges of a Practitioner:

i) while the Practitioner is under investigation by the Medical Executive Committee relating to possible incompetence or improper professional conduct; or

ii) in return for not conducting such an investigation or proceeding.

ARTICLE XIII - DISPUTE RESOLUTION

A. Agreement to Mediation and Arbitration

The Hospital Authority and each Staff Member shall agree, as a condition to each appointment or reappointment to the Staff, that before any action is taken in a court of law to resolve a dispute or seek a remedy with respect to any matter arising under these Bylaws, which is not subject to the Fair Hearing Plan described in Article XII, including (without limitation) any Departmental or Committee function, the parties shall comply with the mediation and arbitration procedures provided below. This requirement shall apply to such actions against the Hospital Authority, its Board members, Officers, and employees and to actions against any Staff Member or members. The arbitration procedure provided herein shall be the exclusive, final and binding remedy for the resolution of any such dispute, and resort to the courts shall be available following

arbitration only to enforce compliance with the arbitration process provided herein and to enforce the award or remedy ordered as the result of an arbitration conducted in compliance with these Bylaws.

B. Referral to Joint Conference Committee

In the event that such a dispute involves a matter appropriate for consideration by the Joint Conference Committee, and a referral of the matter to the Joint Conference Committee is made by the Medical Executive Committee or the Board pursuant to Article X, J., then all further mediation and arbitration procedures shall be delayed for up to three (3) weeks. In the event that the Joint Conference Committee is unable to reach a resolution of the dispute during its initial three (3) week effort, or in the event that the matter is not deemed appropriate for consideration by the Joint Conference Committee, the matter may be referred to mediation by mutual agreement of the Board and the affected Staff Member.

C. Voluntary Mediation

Mediation shall be voluntary and shall be undertaken by mutual agreement of the Board and the affected Staff Member. Mediation shall begin with the selection of mediation representatives. The Staff Member with the disputed matter, on the one hand, and the Board or Administration, on the other hand, shall each designate a representative to enter into mediation. In addition, the representatives shall choose a qualified, neutral mediator, and the mediator shall meet with the representatives in order to assist in developing options and formulating alternatives for resolving the issue. The representatives may also meet, without the mediator, over the course of a three (3) week period, in an effort to achieve resolution of the matter that is agreeable to both sides. The mediation process shall be conducted promptly and in good faith, over a period not to exceed three (3) weeks, unless an extension of such time period is agreed to in writing by the Board or Administration on the one hand, and the other party to the mediation. If the mediation process results in a proposed resolution acceptable to the parties, the proposed resolution shall be reduced to writing by the representatives. If the mediation process fails to result in a proposed resolution acceptable to the parties, and if the dispute does not involve an alleged breach of a legal duty or contractual obligation by any party, then the matter in controversy shall be submitted to the Board, in which case the action of the Board shall be final.

D. Arbitration

In the event the issue in dispute is the type of dispute described in Article XIII, A. above and involves an alleged breach of a legal duty or contractual obligation by any party which would otherwise state a cause of action in a court of law, and in the event that the parties do not elect a mediation process or the mediation process fails to resolve the disputed issue, the sole further remedy shall be submission of the dispute to arbitration pursuant to the provisions of the Georgia Arbitration Code (O.C.G.A. § 9-9-1 et seq.) as the same may be amended from time to time. Arbitration may be instituted upon the written request of the complaining party to the Board. Arbitration shall be conducted by not more than three (3) arbitrators, at least one of whom shall be an attorney-at-law, and all of whom shall be experienced in dealing with hospital/medical

staff issues. Upon application for arbitration, the Board and the affected Staff Member shall be given a reasonable opportunity to agree on the arbitration panel; but in the event no agreement is reached as to the arbitration panel, the provisions of the Georgia Arbitration Code shall be given effect.

The arbitration panel, in making its decision, shall enforce the provisions of Bylaws, Policies, and Rules and Regulations of the Hospital Authority and Staff, and applicable law, and shall include in its deliberations the following considerations:

1) The authority of the Board as the body with ultimate responsibility for all matters relating to the operations of the Hospital to effectively determine Hospital policy and to define and implement the Hospital Authority's goals and objectives in conjunction with the considerations in Article XIII, D.(2) below;

2) The expertise and responsibility of the Medical Executive Committee, other Staff Committees and Departments, and individual medical Practitioners to effectively address clinical issues and issues of professional qualifications and performance in conjunction with the considerations in Article XIII, D.(1) above; and

3) Jurisdiction only over matters that would otherwise have stated a cause of action in a court of law.

The outcome of an arbitration held in compliance with these Bylaws shall be final and non-appealable, and may be enforced in accordance with the Georgia Arbitration Code.

ARTICLE XIV - CONFIDENTIALITY, INDEMNIFICATION AND IMMUNITY

A. Confidentiality of Information

Information with respect to any Practitioner submitted, collected or prepared by any Representative for the purpose of evaluating and reviewing Practitioners' credentials, qualifications and competency, achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Representative nor used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be submitted, collected or prepared by third parties. This Information shall not become part of any particular patient's file or of the general Hospital Authority records.

B. Immunity from Liability

1) No Representative of the Hospital Authority or Staff shall be liable to a Practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his or her duties as a Representative, if such Representative acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the

reasonable belief that the action, statement, or recommendation is warranted by such facts.

2) No Representative of the Hospital Authority or Staff and no third party shall be liable to a Practitioner for damages or other relief by reason of providing Information, including otherwise privileged or confidential Information, to a Representative of the Hospital Authority or Staff or to any other healthcare facility or organization of health professionals concerning a Practitioner or affiliate who is or has been an Applicant to be a member of the Staff or who did or does exercise Clinical Privileges or provide specified services at the Hospital provided that such representative or third party acts in good faith and without malice.

3) No Representative of the Hospital Authority or Staff shall be liable to a Practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his or her duties as a member of a medical review Committee or professional peer review body.

C. Activities and Information Covered

1) Application of Confidentiality and Immunity

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

a) applications for appointment, Clinical Privileges, or specified services;

b) periodic reappraisals for reappointment, Clinical Privileges, or specified services;

c) corrective action;

d) hearings and appellate reviews;

e) patient care audits;

f) utilization reviews; and

g) other Hospital Authority, Department, Service, Section or Committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

2) Relation of Information to Practitioner

The acts, communications, reports, recommendations, disclosures, and other Information referred to in this Article XIV may relate to a Practitioner's

professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

D. Releases

By applying for, or exercising, Clinical Privileges or providing specified patient care services within the Hospital, a Practitioner:

1) authorizes Representatives of the Hospital Authority and the Staff to solicit, provide and act upon Information bearing on his or her professional ability and qualifications;

2) agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative who acts in accordance with the provisions of this Article XIV; and

3) acknowledges that the provisions of this Article are express conditions to his or her application for, or acceptance of, Staff Membership and the continuation of such membership, or to his or her exercise of Clinical Privileges or provision of specific patient services at the Hospital.

E. Cumulative Effect

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of Information, and immunity from liability shall be in addition to other protections provided by law and not in limitation thereof.

F. Indemnification

1) By approving these Bylaws, and by granting Staff Membership to individual Staff Members, the Board agrees on behalf of the Hospital Authority to indemnify:

a) the Chief of Staff for actions within the scope of his or her duties, and

b) individual Staff Members performing services on or for formal review boards or Committees of the Staff or the Hospital Authority, but only while performing functions required or requested by such boards or Committees, and

c) individual Staff Members performing administrative duties for the Hospital Authority (including duties for the Staff as provided in these Bylaws), but only while performing functions within the scope of their administrative duties, and

e) individual Staff Members performing Department, Service or Section services related to monitoring and maintaining: quality

patient care; or appropriate professional conduct and professional performance of Practitioners with Clinical Privileges or Clinical Functions and Allied Health Professionals with Clinical Functions, but only while performing functions required or requested by the Department Chairman, from loss, damage, or expenses arising from claims by a third party, reasonably incurred in connection with the performance of the functions described in Article XIV, F.(2) below, provided that these functions are performed in good faith and without malice and that requirements of these Bylaws and Hospital Authority policies not directly inconsistent with these Bylaws are not intentionally violated. The foregoing indemnification of each covered person is limited to the amounts per claim and aggregate that Physicians are required to have in effect in their professional liability coverage pursuant to Article III, B.(1)(e) above under Hospital policy in effect at the time of the indemnified act.

2) Indemnified Functions

The functions performed by specified Staff Members to which the above indemnity may apply are the following:

a) evaluating, or responding to an evaluation of, the professional qualifications or clinical performance of any provider of healthcare professional services, when done by or for any formal review board or Committee of the Staff or the Hospital Authority or Department Chairman which/who is evaluating the professional qualifications or clinical performance of any provider of healthcare professional services, or which is promoting and/or maintaining the quality of healthcare professional services being provided;

b) communicating, or failing to communicate, to any of the formal review boards or Committees of the Hospital Authority or the Staff, or to the Department Chairman who required or requested the function, information that relates to their activities in carrying out the functions described in paragraph (a) above; and

c) carrying out, or failing to carry out, a decision or directive of any formal review board or Committee of the Staff or the Hospital Authority or Department Chairman that relates to their activities in carrying out the functions described in paragraph (a) above.

3) Insurance

The Board may choose to fulfill its indemnification obligation by maintaining insurance on behalf of the Staff Members against liability incurred or asserted against any Staff Member within the scope of the indemnification provided above. To the extent that the Hospital Authority's professional liability insurance affords coverage to a Staff Member against such liability, the Hospital Authority shall be

relieved to the extent of the insurance coverage from the obligation to indemnify the Staff Member as provided above.

4) Effective Dates

The foregoing indemnification shall be effective for acts or omissions occurring after the date of approval of these Bylaws by the Staff and the Board. Notwithstanding Article XVI or any other provision of these Bylaws, the foregoing indemnification agreement may be (a) unilaterally terminated by Hospital Authority on sixty (60) days' written notice, or (b) amended in any respect at any time upon the written agreement of the Hospital Authority and the Medical Executive Committee, provided that such termination or amendment shall apply only to acts or omissions occurring after the effective date of such termination or amendment.

ARTICLE XV - RULES AND REGULATIONS

A. Adoption by Staff

Subject to the approval of the Board, the Staff shall adopt such Rules and Regulations not in conflict with these Bylaws as may be necessary for the proper conduct of the duties and obligations of the Staff pursuant to these Bylaws. Such Rules and Regulations shall be considered a part of these Bylaws and shall be binding upon Staff Members. Such Rules and Regulations shall become effective upon approval by the Board.

B. Amendment

Rules and Regulations may be amended or repealed at any meeting of the Staff after seven (7) business days' prior written notice or notice at a previous meeting. Adoption of amendments to or repeals of Rules and Regulations shall require a majority (50% + 1) vote of the regular Active Staff Members present and eligible to vote at a meeting at which a quorum is present. The Rules and Regulations shall be reviewed by the Staff at least annually and shall be amended to reflect current practices of the Staff. Amendments to and repeals of Rules and Regulations shall become effective upon approval by the Board.

C. Construction

The Rules and Regulations should not conflict with each other or the Bylaws or Policies of the Medical Staff. However, in case of conflict between the Rules and Regulations and a Policy(ies), the Rules and Regulations shall prevail. In case of conflict between the Rules and Regulations and the Bylaws, the Bylaws shall prevail.

ARTICLE XVI - ADOPTION AND AMENDMENT OF BYLAWS

A. Adoption of Bylaws

These Bylaws shall be adopted by a two-thirds (2/3rds) vote of the Active Staff present at any regular or special meeting of the Staff, shall replace any previous bylaws, and shall become effective when approved by the Board.

B. Amendment of Bylaws

1) Authorization

Amendments to these Bylaws may be proposed by the Medical Executive Committee, the Board, or by a written proposal signed by twenty percent (20%) of the Active Staff. Once any amendment has been proposed, notice of such proposed amendment shall be given, in writing, to all Active Staff Members at least thirty (30) days prior to the next regular meeting of the Staff. The proposed amendment(s) shall be voted upon at that meeting, unless prior to the vote, the Chief of Staff refers the proposed amendment to an appropriate Committee. If the Chief of Staff does so refer the proposed amendment, the Committee considering the proposed amendment shall report its recommendations to the Staff at the next regular or special meeting of the Staff, and the proposed amendment shall be voted upon at that meeting by a simple majority (50% + 1) of those present and eligible to vote. A proposed amendment can be changed by two-thirds (2/3rds) of the voting members present at that meeting. The Bylaws shall be reviewed by the Staff at least once every year and shall be amended as necessary.

2) Required Vote

Adoption of any amendment shall require a positive vote of a majority (50% + 1) of the regular Active Staff Members present and eligible to vote at a meeting at which a quorum is present. Amendments so made shall be subject to approval or disapproval by the Board, which action shall not be unreasonably withheld or delayed.

ARTICLE XVII - POLICIES

A. Purpose

In addition to the Rules and Regulations, the Staff shall be authorized to adopt Policies regarding issues common to the Staff. Each Department is authorized to adopt Policies regarding issues common to the Department. Each Service is authorized to adopt Policies regarding issues specific to the Service. Each Section is authorized to adopt Policies regarding issues specific to the Section. It is intended that these Policies will facilitate an effective, harmonious practice of medicine. Policies will provide a detailed process by which Bylaws, Rules, and Regulations are carried out with greater flexibility and practical application.

B. Adoption

Staff Policies will be developed by appropriate Committees and forwarded through the Medical Executive Committee to the Staff and will be adopted by majority vote. Staff Policies shall become effective upon approval by the Board.

Each Section will develop Policies by majority vote. Each Service will adopt Policies by majority vote. Each Department will adopt Policies by majority vote. Sections, Services and Departments will forward Policies to the Medical Executive Committee for approval. Section, Service, and Department Policies will become effective immediately after approval by the Board. Majority is defined as 50% + 1 of eligible Active Staff Members present at a meeting held at least seven (7) days after notification.

C. Amendment

These Policies shall be reviewed annually or more frequently as the need arises to promote quality patient care. Amendments shall require 50% + 1 votes of eligible members present at a meeting at least seven (7) days after notification.

D. Construction

The Policies shall not conflict with each other or the Bylaws or the Rules and Regulations of the Medical Staff, or the Bylaws, Policies and Procedures or Rules and Regulations of the Hospital Authority. However, in case of conflict between a Policy(ies) and the Rules and Regulations, the Rules and Regulations shall prevail. In case of conflict between a Policy(ies) and the Medical Staff Bylaws, the Bylaws shall prevail.

E. Availability

Policies of the Staff, Departments, Services, and Sections will be bound and kept readily available in Medical Staff Services. Service and Section Policies may also be kept in the appropriate work areas for reference.

ARTICLE XVIII – HISTORY AND PHYSICALS

A. History & Physical Examinations

1) Time for Completion

A history and physical examination ("H&P") shall be completed for each patient and documented in the patient's medical record within the following time frames:

i) Within twenty-four (24) hours after Hospital admission or registration, or prior to surgery or any procedure performed under anesthesia or conscious sedation, whichever comes first; or

ii) Not more than thirty (30) days prior to the patient's Hospital admission or registration, provided that an updated examination of the patient is completed and documented (including any changes in the patient's condition) within twenty-four (24) hours after hospital admission or registration, but prior to surgery or a procedure requiring anesthesia or conscious sedation.

2) Who Can Perform an H & P

a) In the Hospital

i) H&Ps completed in the Hospital may be performed only by Physicians, Oral and Maxillofacial Surgeons, Podiatrist, physician's assistants, nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, or physician's assistant anesthetists with Clinical Privileges or Clinical Functions to perform H&Ps in the Hospital.

iii) A patient admitted for dental care is the dual responsibility of the admitting dentist and the Physician member of the Medical Staff.

a. The Dentist's responsibilities include:

1) Creating a detailed report of the patient's dental condition which justifies admission to the Hospital.

2) Furnishing a detailed description of the examination of the oral cavity and a preoperative diagnosis.

3) Composing a complete operative report, describing the findings and technique used in surgery. If teeth are removed, the operative report shall clearly state the number of teeth and fragments removed.

4) Completing a discharge summary.

b. The Physician's responsibilities include:

1) Performing a medical history and physical examination which assesses the patient's general health in compliance with the Medical Staff Bylaws and if available, updating the H&P within the time frames required by the Medical Staff Bylaws. If the Physician is not available to update the H&P prior to surgery, the H&P may be updated by the

anesthesiologist, certified registered nurse anesthetist or physician's assistant anesthetist with Clinical Privileges or Clinical Functions to perform H&Ps in the Hospital; and

2) Monitoring the patient's general health during hospitalization.

c. A patient receiving dental care shall only be discharged pursuant to written order of the patient's dentists.

iii) H&Ps performed by physician's assistants, nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, or physician's assistant anesthetists must be countersigned by the responsible Physician within the time frame required for countersignature for other medical record entries.

b) Prior to Admission & Updates of H&P

i) An H&P completed within thirty (30) days before the patient's admission or registration may be performed by: (1) a Physician with Clinical Privileges to perform H&Ps in the Hospital; or (2) a physician's assistant, nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or physician's assistant anesthetist with Clinical Functions to perform H&Ps in the Hospital, countersigned by a Physician with Clinical Privileges to perform H&Ps in the Hospital; (3) a Physician who is not a member of the Medical Staff provided that the H&P is validated by a Medical Staff Member, with Clinical Privileges to perform H&Ps in the Hospital by an update note in the medical record within twenty-four (24) hours after the patient's admission or registration or prior to surgery or any procedure under anesthesia or conscious sedation, whichever occurs first; or (4) a physician's assistant, nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or physician's assistant anesthetist, provided that the H&P is countersigned by a Physician and is validated by a Medical Staff Member with Clinical Privileges to perform H&Ps in the Hospital by an update note in the medical record within twenty-four (24) hours after the patient's admission or registration or prior to surgery or any procedure under anesthesia or conscious sedation, whichever occurs first.

ii) An updated examination of the patient must be performed and documented by a Physician, physician's assistant, nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or physician's assistant anesthetist with Clinical Privileges or Clinical Functions to perform H&Ps in the Hospital. A medical record entry of the updated examination must be completed and documented within twenty-four (24) hours after the

patient's admission or registration or prior to surgery or a procedure under anesthesia or conscious sedation, whichever occurs first.

B. Documentation of History & Physicals

1) Documentation of the H&P and any updates of an examination must be included in the patient's medical record within twenty-four (24) hours after admission or registration and prior to surgery or other procedure requiring anesthesia or conscious sedation, whichever occurs first.

2) A durable, legible copy of the report of H&Ps performed within thirty (30) days before the patient's admission or registration must be included in the patient's medical record, along with documentation of the update examination.

3) When more than one (1) Physician, physician's assistant, nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or physician's assistant anesthetist participates in performing, documenting, and authenticating an H&P for a single patient, the Physician who authenticates the H&P will be held responsible for its contents.

4) When either an admission note updating pertinent findings or a history and physical is not recorded before surgery or procedure under anesthesia or conscious sedation, the surgery or procedure will be cancelled unless the attending Physician states in writing that such delay would be detrimental to the patient.

5) The required content of patient H&Ps is established by Medical Staff Policy, MS 3, as amended from time to time.

Adopted by the
SGMC Health Medical Staff
February 20, 2024

R. Jared Sanders, MD, Chief of Staff

Approved by
South Georgia Medical Center Inc, d/b/a SGMC Health
February 21, 2024

By: _____
Sam Allen, Chairman