SOUTH GEORGIA MEDICAL CENTER BERRIEN CAMPUS

MEDICAL STAFF BYLAWS

2022

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SOUTH GEORGIA MEDICAL CENTER BERRIEN 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.

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 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. To the extent authorized by the Board, Allied Health Professionals may apply for Clinical Functions and exercise Clinical Functions in the Hospital as provided in these Bylaws. At this time, the Board has determined that the categories of individuals eligible to exercise Clinical Functions as Allied Health Professionals are: physician's assistants, nurse practitioners, certified nurse midwives, and certified registered nurse anesthetists.

"Applicant" means a person applying for Medical Staff Membership and/or Clinical Privileges or Clinical Functions.

"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" mean 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.

"Chief Medical Officer" means the individual serving as a physician-member of the Administration in the dual capacity of Chief Medical Officer and Medical Staff Services.

"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.

"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 Hospital Authority under the name South Georgia Medical Center Berrien Campus ("SGMC Berrien"). As the term is used in these Bylaws, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital.

"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 who is licensed in the State of Georgia to provide patient care independently. 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. At this time, the Board has determined that individuals specializing in podiatry, dentistry, psychology, or optometry are eligible for Clinical Privileges as Limited License Professionals.

"Medical Staff" or "Staff" means the Physicians or Oral or Maxillofacial Surgeons 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.

"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 or 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 or Oral or Maxillofacial Surgeon 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, Medical Staff Policies or Rules and Regulations, and in other Hospital Authority and Medical Staff Policies.

"Provider" means any Practitioner, Limited License Professional or Allied Health Professional.

"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 or Committee thereof.

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

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

"Telemedicine Privileges" means the authorization granted by the Board 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.

ARTICLE I- NAME

The name of these Bylaws shall be the Bylaws of the Medical Staff of the South Georgia Medical Center Berrien Campus.

ARTICLE II- PURPOSES, RESPONSIBILITIES & PRIVACY PRACTICES

A. Statement of Purpose

The purpose of these Bylaws is to provide an organizational framework through which the Medical Staff shall carry out their responsibilities and through which the professional activities of Medical Staff Members and individuals exercising Clinical Privileges and Clinical Functions in the Hospital are governed and made accountable to the Medical Staff and the Board.

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.

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

B. Primary Purposes & Responsibilities

The primary purposes and responsibilities of the Medical Staff are to:

(1) Provide oversight of care, treatment and services provided by Practitioners, Limited License Professionals and Allied Health Professionals in the Hospital;

(2) Provide mechanisms for recommending to the Board the appointment and reappointment of qualified and competent Practitioners and Allied Health Professionals;

(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, or services of the Hospital Authority, consistent with resources locally available;

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

(5) Serve as a primary means for accountability to the Board concerning professional performance of Practitioners and others with Clinical Privileges authorized to practice at the Hospital with regard to the quality and appropriateness of health care;

(6) Provide leadership and participate in the following Hospital processes: quality assessment, performance improvement, risk management, case management, utilization review, resource management, and other Hospital initiatives to measure and improve performance;

(7) Provide a 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;

(8) Participate in identifying community health needs and establishing appropriate Hospital goals;

(9) Foster a high level of professional performance and ethical conduct of Practitioners, Limited License Professionals and Allied Health Professionals through appropriate delineation of the Clinical Privileges and Clinical Functions and through an ongoing evaluation and review of the performance;

(10) Monitor and enforce compliance with these Bylaws, Medical Staff Rules and Regulations, Medical Staff Policies, and Hospital policies;

(11) Assist the Board by serving as a professional review body in conducting professional review activities, including, focused professional practice evaluations, ongoing professional practice evaluations, quality assessment, performance improvement, and peer review;

(12) When warranted, pursue corrective action with respect to members of the Medical Staff or those individuals granted Clinical Privileges; and

(13) Maintain Medical Staff compliance with applicable accreditation requirements and Federal, State, and local laws and regulations.

C. Privacy Practices

Each Medical Staff Member and each Practitioner, Limited License Professional and Allied Health Professional with Clinical Privileges, Clinical Functions, Temporary Clinical Privileges or Temporary Clinical Functions at the Hospital ("Hospital Healthcare Providers") shall be part of the Organized Health Care Arrangement with the Hospital, which is defined in the HIPAA Privacy Regulations, 45 C.F.R. §164.501, as a clinically-integrated care setting in which individuals typically receive health care from more than one healthcare provider. This arrangement allows the Hospital to share information with the Hospital Healthcare Providers and the Hospital Healthcare Providers' offices for purposes of payment and operations. The patient will receive a single Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with Hospital Healthcare Providers.

ARTICLE III - MEDICAL STAFF MEMBERSHIP

A. Nature of Membership

Staff Membership confers privileges and Prerogatives, but only as stated in these Bylaws and as granted by the Board. Staff Membership shall be extended only to those professionally competent Physicians and Oral or Maxillofacial Surgeons 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.

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 or Maxillofacial Surgeon;

(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 DEA registration;

(d) If applying for Active Staff Membership, maintain a functional office within a sixty (60) mile radius of the Hospital;

(e) Have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Board as established by Hospital Authority policy, as adopted by the Board from time to time;

(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 an investigation or 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) Agree to fulfill all responsibilities regarding emergency call as required by his/her Staff category;

(k) Have or agree to make coverage arrangements with other Staff Members for those times when the individual will be unavailable as required by his/her Staff category;

(l) If applying for Clinical Privileges to provide clinical services in a specialty in which the Hospital has a contract with a Practitioner or a group of Practitioners ("Contract Provider") to exclusively provide such services in the Hospital ("Hospital Contract"), have a contract to provide such services in association with the Contract Provider pursuant to a Hospital Contract;

(m) If the individual is a Physician, has demonstrated that the individual: (a) graduated from a school of medicine accredited by the Liaison Committee on Medical Education or the Committee on Accreditation of Canadian Medical Schools; or (b) graduated from a college of osteopathic medicine accredited by the American Osteopathic Association; or (c) graduated from a foreign medical school and received certification by the Educational Commission for Foreign Medical Graduates ("ECFMG");

(n) If the individual is an Oral or Maxillofacial Surgeon, have graduated from an accredited dental school;

(o) If the individual is a Physician and has successfully completed a residency training program approved by the Accreditation Council for Graduate Medical

Education or the American Osteopathic Association in the field of specialty in which the individual seeks Clinical Privileges;

(p) If the individual is an Oral or Maxillofacial Surgeon, have successfully completed an oral or maxillofacial surgery training program accredited by the Council on Dental Education and Licensure of the American Dental Association; and

(q) Meet one (1) of the following:

(i) Maintain Board Certification from a specialty board recognized by the American Board of Medical Specialties, the American Board of Oral and Maxiofacial Surgery, or the American Osteopathic Association, as applicable; or

(ii) If not Board Certified at the time of appointment, have completed his/her residency training within the last six (6) years; or

(iii) Demonstrate to the satisfaction of the Medical Executive Committee and the Board that he or she has competence, training and education equal to or equivalent to that required for such certification.

(3) Applicants for Initial Privileges who meet all Threshold Criteria for Membership other than Article III, B(1)(b) (Georgia licensure), B(1)(c) (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 and policies of the Hospital, 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.

F. History and Physical Examinations

(1) **Timing of History and Physical.** A history and physical examination shall be completed and shall be documented in the patient's medical record as follows:

(a) 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

(b) Not more than thirty (30) days prior to the patient's admission or registration to the Hospital, 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 any procedure requiring anesthesia or conscious sedation.

(2) **Update of History and Physical Prior to Certain Procedures.** If a patient is scheduled to undergo surgery or any other procedure under anesthesia or conscious sedation, and such patient has received a history and physical, but such history and physical was not within twenty-four (24) hours prior to the scheduled

surgery or other procedure under anesthesia or conscious sedation, then the history and physical of such patient must be updated within twenty-four (24) hours prior to surgery or procedure under anesthesia or conscious sedation.

(3) **Persons Authorized to Perform History and Physical Examinations.** History and physical examinations may be performed and documented only by Physicians, physician's assistants, and nurse practitioners with appropriate Clinical Privileges or Clinical Functions to perform history and physical examinations. History and physical examinations performed by a physician's assistant or nurse practitioner must be countersigned by the responsible supervising Physician as soon as possible, but no later than thirty (30) days after the patient's discharge. Dentists or Podiatrists may update history and physical examinations by a person authorized to perform such exams.

(4) **History and Physical Examinations Prior to Admission.**

(a) A history and physical completed within thirty (30) days before the patient's admission or registration may be performed by: (1) a Physician with appropriate Clinical Privileges to perform history and physical examinations in the Hospital; or (2) a physician's assistant or nurse practitioner with Clinical Functions to perform history and physical examinations in the Hospital; or (3) a Physician who is not a member of the Medical Staff, provided that the history and physical is validated by a Physician, physician's assistant, or nurse practitioner with Clinical Privileges or Clinical Functions to perform history and physical examinations in the Hospital by an update note completed as provided herein.

(b) A history and physical examination completed within thirty (30) days before the patient's admission or registration must be updated. An updated examination of the patient, which should be used to determine changes in the patient's condition, must be performed and documented by a Physician, physician's assistant, or nurse practitioner with Clinical Privileges or Clinical Functions to perform history and physical examinations in the Hospital. The updated examination must be completed and documented in the patient's medical record within twenty-four (24) hours after the patient's admission or registration or prior to surgery or any other procedure under anesthesia or conscious sedation, whichever occurs first. The entry in the medical record of any update must include documentation of any changes in the patient's condition.

(5) **Documentation of History and Physical Examinations.**

(a) Documentation of each history and physical 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.

(b) A durable, legible copy of the report of any history and physical 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 updated examination.

(c) When more than one (1) Physician, physician's assistant, or nurse practitioner participates in performing, documenting, and authenticating a history and physical for a single patient, the person who authenticates the history and physical will be held responsible for its contents.

(d) When either an admission note updating pertinent findings of 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.

(6) Content of History and Physical Examinations.

Documentation for each history and physical examination should include at least the following:

(a) Chief Complaint;
(b) History of Present Illness;
(c) Relevant past, medical and surgical, social, and family histories appropriate to the patient's age;
(d) Age-appropriate review of systems;
(e) For children and adolescents, as appropriate, an evaluation of the patient's developmental age, consideration of educational needs and daily activities, immunization status, family and guardian's expectation for involvement in the assessment, treatment, and continuous care of the patient;
(f) Current physical and mental assessment;
(g) A statement of conclusions or impressions from the exam;
(h) Current medications and the dosages for such medications;
(i) Known allergies; and
(j) If the patient will undergo any procedure under any form of anesthesia or conscious sedation, history of any adverse or allergic drug reactions with anesthesia or sedation.

ARTICLE IV - CATEGORIES OF THE MEDICAL STAFF

A. The Active Medical Staff

(1) Qualifications

The Active Medical Staff ("Active Staff") shall consist of Physicians and Oral or Maxillofacial Surgeons 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) Have advanced from Provisional Status of the Active Staff category pursuant to Article IV, I. below; and

(d) Are regularly responsible for patient care in the Hospital, and, except for contract Physicians working in the emergency room, maintain a functional office and residence within a sixty (60) mile radius of the Hospital.

(2) Duties

All Active Staff Members shall belong to a specific Department, if applicable, 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;

(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; and

(e) Participating in performance improvement, monitoring and peer review activities as may be assigned by the Chief of Staff, Committees, and if applicable, the Department Chairman.

(3) Prerogatives

All Active Staff Members shall be eligible to:

(a) Admit patients;

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

(c) Vote;

(d) Hold office; and

(e) Serve on Committees.

B. 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 and Oral or Maxillofacial Surgeons 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 or Oral or Maxillofacial Surgeon 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 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, if applicable, 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 on Committees.

C. The Honorary Medical Staff

(1) Qualifications

The Honorary Medical Staff ("Honorary Staff") shall consist of Physicians and Oral or Maxillofacial Surgeons 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 are not required to meet the Threshold Criteria for Membership set forth in Article III or complete the provisional status period provided in Article IV, I.

(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.

D. The Telemedicine Staff

(1) Definition of Telemedicine Privileges

"Telemedicine Privileges" means the authorization granted by the Board, after considering the recommendations of the Medical Executive Committee, 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.

(2) Qualifications

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. 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. When primary source verification is not attainable, the Hospital may use the Information regarding the Physicians' qualifications and competency from the distant site if all of the following requirements are met: (a) the distant site is accredited by The Joint Commission; (b) the Physician maintains clinical privileges at the distant site for those services to be provided at the Hospital; (c) 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 Privileges in Telemedicine as granted pursuant to these Bylaws.

(b) Telemedicine Staff shall not be eligible to admit or attend patients in the Hospital, to hold office, vote, 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.

(d) Final interpretation, reports, and/or recommendation of treatment shall be the responsibility of Active Staff Members.

E. The Hospitalist Staff

(1) Qualifications - Hospitalists

Physicians who function as Hospitalists must meet the Threshold Criteria for Membership. 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.

(2) Prerogatives

Hospitalist Staff Members shall be eligible to:

(a) Admit patients;

(b) Exercise Clinical Privileges specifically granted to the Staff Member pursuant to these Bylaws;

(c) Vote;

(d) Attend meetings of the Medical Staff and applicable Departments, if any; and

(e) Serve on Committees.

(3) Responsibilities

(a) Except as otherwise provided, Hospitalist Staff Members carry the same obligations as other members of their Department, if applicable, and shall fulfill other duties and requirements of Staff Membership.

(b) Hospitalist Staff Members are expected to attend Staff and Department meetings, but shall have no right to vote at such meetings.

(c) Hospitalist Staff Members are entitled to serve on Committees when eligible.

(d) Since they 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 Department in which they practice.

(e) Hospitalists practice as inpatient physicians and do not perform follow-up visits following discharge unless an exception is recommended by the Medical Executive Committee and approved by the Hospital Authority.

F. 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 and consultation with patients within sixty (60) miles 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, if any, (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.

G. The Limited Active Primary Care Medical Staff

(1) Qualifications

The Limited Active Primary Care Medical Staff ("Limited Active Staff") shall consist of those qualified Physicians who:

(a) Meet Threshold Criteria for Staff Membership.

(b) Have satisfactorily completed appointment to the Provisional Status of the Limited Active Staff category.

(c) Have been granted Staff Membership and Clinical Privileges as provided in these Bylaws in one of the following specialties only: Internal Medicine, Family Practice or Pediatrics.

(d) Are involved in the care and treatment of less than twenty-five (25) patients per year as measured by patient contacts, which are defined as admissions, consultations, and procedures (inpatient or outpatient). Evaluations and services performed in the Emergency Department, if any, are excluded from the calculation of patient contacts. Involvement in a greater number of patient contacts shall result in automatic transfer to the Active Staff.

(e) Shall provide information as may be required 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 Duties

All Limited Active Staff Members:

(a) Must fulfill all obligations set forth in these Bylaws;

(b) Must accept consultation assignments and Emergency Department follow-up assignments as determined by Medical Staff Policy from time to time;

(c) Are excused from Emergency Department on-call responsibilities unless there is a finding by the Medical Executive Committee and the Board that there are insufficient Active Staff Members in a particular specialty to perform these responsibilities; and

(d) Must participate in performance improvement, monitoring, medical review and peer review activities, and respond fully and in a timely manner to any inquiries regarding the care of patients at the Hospital.

(3) Prerogatives

Limited Active Staff Members shall be eligible to:

(a) Admit patients;

(b) Exercise Clinical Privileges specifically granted to the Staff Member pursuant to these Bylaws;

(c) Vote;

(d) Attend meetings of the Medical Staff and applicable Departments, if any;

(e) Serve on Committees.

(4) Limitations

Limited Active Staff Members:

(a) May not serve as Chief of Staff, Vice Chief, or Secretary/Treasurer;

(b) May not serve as Department Officer (Chairman or Vice Chairman) and may not serve on the Medical Executive Committee.

H. 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 Staff 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) Accept Emergency Department follow-up assignments;

(b) May provide History and Physicals for patients who are admitted for inpatient or outpatient Hospital services, with appropriate updates by attending physicians;

(c) May attend meetings of the Medical Staff and applicable Departments, if any;

(d) May serve on Committees;

(e) May refer patients to members of the Active Staff or Limited Active Staff for admission and/or treatment;

(f) 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 or care to patients;

(g) Are permitted to order outpatient Hospital diagnostic services; and

(h) If providing services as an employee or contractor of the Hospital, may be granted Clinical Privileges to provide services in off-site clinics or Departments, if any, owned by the Hospital.

(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 write orders (other than for outpatient diagnostic testing) or make medical record entries or actively participate in the provision or management or care to patients;

(c) May not hold Medical Staff office; and

(d) May not vote.

I. Provisional Status

(1) Duration

Unless specifically waived by the Board, all initial appointments to the Active Staff and Limited 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, I.(5) below, not to exceed a total of four (4) years.

(2) Duties

Each Provisional Status Staff Member shall attend meetings of the Staff and the Department, if any, 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. The Provisional Status Staff Member shall perform other duties in the same manner as regular members of his/her assigned Staff Category. Provisional Status Staff Members shall belong to a specific Department (if applicable) and fulfill all duties and obligations required of regular members of his/her assigned Staff Category.

(3) Prerogatives

Each Provisional Status Staff Member shall be entitled to exercise the Prerogatives as may be exercised by regular members of his/her Staff category except that Provisional Status Staff Members shall not be eligible to: (i) hold Staff office; (ii) vote during the first year of Provisional Status, except within Committees; (iii) serve as Chairman of a Committee; (iv) hold Staff office; or (v) serve on the Medical Executive Committee.

(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 Status Staff Member, the purpose of the period of evaluation shall be to evaluate the Provisional Status 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 total 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 the Department to which the Staff Member is assigned, if applicable, shall report to the Medical Executive Committee whether the Staff Member has satisfactorily demonstrated, through the evaluation process provided for in Article IV, I.(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. In the event the Provisional Staff Member is not part of a Department, the Medical Executive Committee, or its designee, shall decide whether the Provisional Status Staff Member has satisfactorily demonstrated his or her ability for continued Staff Membership.

(b) The Medical Executive Committee shall formulate a recommendation as to whether the Provisional Status Staff Member is eligible for regular status on the Active Staff, or if not, whether the Provisional Status Staff member is eligible for another term of Provisional Status. The recommendation of the Medical Executive Committee is forwarded to the Board.

(c) 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 Provisional Status Staff Member as defined in Article XII, in which case the Provisional Status Staff Member shall be entitled to the hearing and appeal procedures provided in Article XII.

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, 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 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 or his or her designee, temporary Clinical Privileges may be granted to a Practitioner in the following circumstances:

After receipt of an initial application for Staff Membership or Clinical Privileges, including a request for specific temporary Clinical Privileges, and upon the basis of Information then available which may reasonably be relied upon as to the competence and ethical standing of the Applicant, an appropriately licensed Applicant may be granted temporary privileges, limited to those Clinical Privileges in which the Applicant has demonstrated sufficient education, training and ability as determined by the appropriate Department or Departments, if applicable, Temporary privileges will not be granted until the Applicant's completed application and credentials file and completed peer review file have cleared the Medical Executive Committee. In no event shall the duration of the Applicant's temporary Clinical Privileges exceed the period during which the application for Staff Membership, Clinical Privileges or Clinical Functions is pending. Such temporary Clinical Privileges must be renewed each month, not to exceed a total of one hundred twenty (120) days.

(2) When Required For Important Patient Care Need

With the written concurrence of the Administrator or his or her designee and the Chief of Staff or his or her designee, temporary privileges may be granted to a Provider to fulfill an important patient care, treatment or service need including the following circumstances if, unless otherwise provided below, the application reflects current licensure, and does not reflect any previously successful challenge to licensure, involuntary termination of medical staff membership, resignation while under investigation, or reduction or denial of privileges:

(a) Care of Specific Patients

Upon written application, and upon the basis of Information then available which may reasonably be relied upon as to the competence and ethical standing of the Provider, an appropriately licensed Provider who is not a member of the Staff may be granted temporary Clinical Privileges or Clinical Functions for the care of one or more specific patients, limited to those Clinical Privileges or Clinical Functions in which the Applicant has demonstrated sufficient education, training and ability as determined by the appropriate Department or Departments, if an applicable Department exists. Such Clinical Privileges or Clinical Functions shall be restricted to the treatment of not more than six (6) patients in any one year by any Provider, after which such Provider shall be required to apply for Staff Membership and/or non-temporary Clinical Privileges or Clinical Functions before being allowed to attend any additional patients. Such temporary Clinical Privileges or Clinical Functions shall cease upon the discharge from the Hospital of the specific patients.

(b) *Locum Tenens*

Upon written application, and upon the basis of Information then available which may reasonably be relied upon as to the competence and ethical standing of the

Provider, an appropriately licensed Provider who is not a member of the Staff may be granted temporary Clinical Privileges or Clinical Functions as a *locum tenens* for a Staff Member, LLP or AHP, limited to those Clinical Privileges in which the Applicant has demonstrated sufficient education, training and ability as determined by the appropriate Department or Departments, if an applicable Department exists. Procedures required for Providers to apply for Temporary Clinical Privileges or Clinical Functions as a *locum tenens* and the responsibilities of Staff Members who have *locum tenens* coverage are defined from time to time by the Medical Staff Policy. Temporary *Locum Tenens* Clinical Privileges or Clinical Functions may be granted for time periods not to exceed sixty (60) days and may be renewed for one (1) additional time period per calendar year, 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 Provider's services as a *locum tenens*. While exercising Temporary *Locum Tenens* Clinical Privileges, *locum tenens* Providers shall be available within a sixty (60) minute drive (legal driving speed) of the Hospital.

(c) Temporary Clinical Privileges for Specific Need

With invitation and approval of a Staff Officer, a duly licensed Provider, who is not a member of the Staff, may submit a written application asking to be granted specific limited Clinical Privileges or Clinical Functions. In addition to the written request, which shall be submitted on a form supplied by the Hospital, information relating to the current licensure, competence and training, and ability of Provider to perform requested Clinical Privileges or Clinical Functions, in accordance with the requirements established by the Chief of Staff, shall be submitted. Such specific limited Clinical Privileges or Clinical Functions granted shall be exercised only in accordance with any specific guidelines that the Chief Medical Officer may deem necessary and appropriate to assure continuous quality patient care, provided such guidelines are not capricious and arbitrary. Such Clinical Privileges or Clinical Functions may be granted for a specific period of time as recommended by the Chief of Staff not to exceed one (1) year. After the initial period, the Clinical Privileges or Clinical Functions may be extended for an additional period, not to exceed twelve (12) months and not to exceed the specific need, as recommended by the Chief of Staff and as approved.

(3) Conditions

In the exercising of temporary Clinical Privileges, the Provider shall act under the supervision of the Medical Executive Committee and the appropriate Department, if applicable. AHPs must also act under the supervision of a Staff Member. Special requirements of supervision and reporting may be imposed by the Department or the Medical Executive Committee on any Provider granted temporary Clinical Privileges or Clinical Functions. Temporary Clinical Privileges or Clinical Functions 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 Provider 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 Provider's professional qualifications or professional ability to exercise any or all of the temporary Clinical Privileges or Clinical Functions granted, the Administrator (with the concurrence of the Chief of Staff or his or her designee) may terminate any or all of such Provider's temporary Clinical Privileges or Clinical Functions, provided that where the life or well-being of a patient under the care of the Provider is determined to be endangered by the continued treatment by the Provider, termination may be effectuated by any person, Committee or Board entitled to impose precautionary suspension under Article XI. In the event of such termination, the Provider's patients then in the Hospital shall be assigned to a Staff Member with appropriate Clinical Privileges by the Chief of Staff in consultation with the relevant Department Chairman, if applicable. 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 Privileges or because of any termination or suspension of temporary Privileges, unless such an event is required to be reported pursuant to the Health Care Quality Improvement Act. An AHP shall not be entitled to procedural rights offered by Article XII.

D. Emergency Privileges

In the case of an emergency, any Provider, to the degree permitted by the Provider'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 Providers 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 Provider 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 current licensure in the State of residence or practice; valid government issued photo identification; and at least one of the following: 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 above;

(b) Notify the appropriate Department Chairman, if applicable;

(c) Maintain a record of the Provider's name, address, and period of service; and

(d) Provide an identification badge for the Provider.

(4) The Department Chairman or Staff Officers, or their designees, will provide supervision of the Practitioner(s) working in their 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 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 Medical Executive Committee shall prepare and submit to the Board for its approval, 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 Medical Executive 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 as provided in the Manual. 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. Authorization of Staff Member Assistants are governed by the terms of the Manual.

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 Chief Medical Officer or his or her designee a pre-application on the form adopted by the Medical Executive Committee and approved by the Chief Medical Officer. The pre-application shall contain objective criteria to identify those Practitioners who do not satisfy the threshold eligibility criteria for the Clinical Privileges 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.

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, the Board will consider whether it will allow the Privilege. If the Board allows the Privilege, the Medical Executive Committee will develop criteria for the Privilege. 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 Chief Medical Officer or his or her designee. The Chief Medical Officer will determine if the application is complete and will determine if the pre-applicant meets the Threshold Criteria, and if so, the Chief Medical Officer 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 Medical Executive Committee, which shall submit its findings to the Board. The Board, in its discretion, 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 thus not an adverse action) 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 Chief Medical Officer. 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 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 Department in which the Applicant is seeking Clinical Privileges, if any, the Medical Executive Committee, the Chief of Staff, or the Chief Medical Officer, or if such tests or evaluation are requested by the Medical Executive Committee or Chief of Staff 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 established by the Board shall be made payable to the Hospital Authority and shall be submitted to the Administrator. All such fees shall be designated and used for continuing medical education for the Medical Staff. 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, 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 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 shall begin the appointment process by immediately transmitting the application and all supporting materials (collectively, the "Application Materials") to the Chairman of each Department in which the Applicant seeks Clinical Privileges, if any, and by contacting the National Practitioner Data Bank to obtain any relevant information concerning the Applicant. In the event that a Department has not been established for the Clinical Privileges which the Applicant seeks, the Application Materials shall be transmitted directly to the Medical Executive Committee.

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.(5)(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 Department Chairman or the Medical Executive Committee, as the case may be, the Administrator shall forward any relevant Information received from the National Practitioner Data Bank to each Department Chairman or the Medical Executive Committee, as appropriate.

(3) Department Action

If the Application Materials are transmitted to one (1) or more Department Chairmen, then each 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 Department Chairman shall make a written report to the Medical Executive 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 Department Chairman shall be transmitted with the report.

(4) Medical Executive Committee Action

Upon receipt of the Application Materials and the written report of each Department Chairman, if any, 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 Department(s) in which Clinical Privileges are sought, if any, whether the Applicant has established and meets all of the necessary qualifications for any requested category of Staff Membership or any requested Clinical Privileges. Prior to the last scheduled monthly meeting of the Board falling within the time limits set forth in Article VI, A.(5)(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.(5) below. Any minority views may also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

(5) 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 ninety (90) 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 Board for its 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 to which he or she is assigned, if any, 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, the Applicant will be assigned to only one (1) Department, but the exercise of Clinical Privileges will be governed by policies of and reviewed by all Departments 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.(5)(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 be in the form described in Article XI, A(4).

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.

(6) 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.

(7) 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. 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 Medical Executive Committee will investigate and evaluate the technique, operation, medication, procedure, or therapy. The Medical Executive Committee make a recommendation to the Joint Conference Committee and forward all relevant documents, references, and reports 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 Medical Executive Committee making a recommendation 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.(5).

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 once each calendar year. All reappointments to the Staff or renewals of Clinical Privileges shall be for a period of no more than two (2) years, with Staff Membership and Clinical Privileges expiring at midnight on March 31st in the year of the second anniversary after the previous appointment for Staff Members or other Practitioners. 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.

(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 Chief Medical Officer and provided to the Applicant by the Administrator or his or her designee approximately four (4) months prior to the expiration of the Applicant's then 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:

(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 and the threshold criteria for the Clinical Privileges requested, 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 shall within ten (10) business days of receipt and verification of completeness forward the Application Form for Reappointment to the Medical Executive 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 (1) 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 Medical Executive Committee, which shall submit its findings and 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 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 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, if any, and participation in required Staff and Department affairs and Committees, if any;

(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, if any.

A written record of matters considered in each Practitioner's periodic reappointment or renewal appraisal shall be made a part of the permanent files at the Hospital. 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) Medical Executive Committee Action

(a) 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.

(b) The Medical Executive 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 Medical Executive Committee shall, as it deems appropriate, seek input regarding reappointment or renewal of Clinical Privileges from the Chairman of the Clinical Department(s) to which the Practitioner is assigned, if any. The Medical Executive 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 Medical Executive Committee shall fully appraise the health status of any such Practitioner during the reappointment process. The Medical Executive 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.

(c) Following its evaluation and review of the Practitioner, including a review of the Application Form for Reappointment and any information obtained from the National Practitioner Data Bank, the Medical Executive Committee shall make a recommendation concerning the Practitioner. 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 recommendation, 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.

(d) 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.

(e) 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 be in the form described in Article XI, A(4).

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.

(6) 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 shall notify 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.(5)(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.(5)(c), and the hearing and appeal mechanism outlined in Article XII shall be followed.

(7) Conditional Reappointment

(a) 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.

(8) 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.

(9) Reapplication

The Medical Executive Committee shall submit with any 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 evaluated and reviewed by at least two (2) other Practitioners designated by the Medical Executive Committee to determine the subject Practitioner's suitability to exercise the Clinical Privileges. In order for the subject Practitioner to continue to perform the new Clinical Privileges, the Practitioners performing the review and evaluation must furnish the Medical Executive Committee with a signed certification(s) which: (i) describes the types and numbers of cases observed and the evaluation of the Practitioner's performance; (ii) states whether or not the Practitioner appears to meet all of the qualifications for exercising such Clinical Privileges; (iii) states that the Practitioner has satisfactorily demonstrated, through the applicable evaluation process, his or her ability for continued exercise of Clinical Privileges; (iv) attests that sufficient treatment of patients has occurred to properly evaluate the Clinical Privileges being exercised; and (iv) in the case of Staff Members, states 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.

(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, I. of these Bylaws. The Practitioner shall be entitled to a hearing upon request, pursuant to Article XII, unless the failure to obtain such certificate 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 special requirements for consultation as a condition to the exercise of particular Clinical Privileges. These shall be 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.

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 the Chief Medical Officer 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, I, provided, however, such status shall only remain provisional for one (1) year unless extended pursuant to Article IV, I.

(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. Effect of Contract Termination on Medical Staff Membership or Clinical Privileges

The terms of any written contract between the Hospital and a Practitioner or contractor shall take precedence over these Bylaws, as now written or hereinafter amended. Such contract may provide, for example, that the Staff membership and Clinical Privileges of a Practitioner or individual providing services pursuant to a contract are automatically terminate or modified in the event of termination of the written contract, and the Practitioner or individual providing services pursuant to the contract shall have no rights to a hearing and appeal otherwise with regard to such termination or modification of Staff membership or Clinical Privileges.

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 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 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 Medical Staff year.

D. Vacancies

Vacancies in office, other than those of Chief of Staff and Vice Chief and 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 and 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 Medical Executive Committee 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 and 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 record and maintain complete minutes of all regular and called meetings of the Staff, shall maintain attendance records at 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 and assist the current Officers.

(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

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. An Officer of the Staff may be removed from office by two-thirds (2/3^{rds}) vote of the regular Staff Members who are eligible to vote for Staff Officers.

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. Bi-monthly Meetings

Regular meetings of the Staff will be held every other month. In addition to matters of organization, the programs of such meeting will include a report of actions of the Medical Executive Committee.

C. Special Meetings and Special E-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.

In addition to being able to call an in-person special meeting of the Staff, the Chief of Staff or the Medical Executive Committee may call a special e-meeting to consider any issue or matter affecting the Staff, except that a special e-meeting may not be used to consider and vote upon a provisional amendment to these Bylaws. Notice of a special e-meeting shall be provided to the Staff in writing at least seven (7) business days prior to the date of the meeting.

Even if a matter receives a positive vote pursuant to a special e-meeting, if more than ten percent (10%) of the Staff Members eligible to vote move to call an in-person special meeting to consider the matter, the Chief of Staff shall call a special in-person meeting for such purpose. In such event, the votes cast pursuant to the special e-meeting shall not be counted and shall be of no effect, and the matter will be presented for consideration and vote at the in-person special meeting.

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 a majority of Staff Members who are eligible to vote and are present at the meeting. Each 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 Staff Members present and eligible to vote.

F. 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

In the event that three (3) or more Practitioners maintain Clinical Privileges in surgery specialties, the Department of Surgery shall be formed. In the event that three (3) or more Practitioners maintain Clinical Privileges in medicine specialties, the Department of Medicine shall be formed.

If the applicable Department(s) exist, each Staff Member shall belong to such Department and participate in the regular functions of such Department. 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

(1) Departments formed pursuant to Article IX, A. shall be:

(a) Surgery; and

(b) Medicine.

C. Officers of Departments

(1) Election

Each Department shall elect, from among the members of the Department who are 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 and Vice-Chairman ("Department Officers"). 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 election for the first Department Officers shall be held at the first Department meeting called by the Chief of Staff. The Chairman and Vice-Chairman 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.

(2) Term

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

(3) Vacancy

If a vacancy in the office of any Department officer 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 or Vice-Chairman may be removed by a two-thirds ($2/3^{rds}$) vote of the Department's Active Staff Members. A Department Chairman or Vice-Chairman 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.

(5) Duties

(a) Department Chairman

The duties of the Department Chairman shall be as follows:

(i) 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, rendered by 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 policies 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 Medical Executive Committee concerning appointment and classification, including recommending specific Clinical Privileges or Clinical Functions for appointment or reappointment with respect to Applicants, Practitioners or AHPs 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 requesting initiation of corrective action investigation 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 Medical Executive Committee 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.

D. 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.

(2) Privileges

As requested by the Medical Executive Committee, each Department shall propose 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 services and other patient care services and with administrative 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, 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 Medical Executive Committee, including: (a) performance of chart review as needed, with the prior approval of the Administrator; (b) interviewing Staff Members (or others exercising Clinical Privileges, Clinical Functions, or both) by letter or personal interview; (c) interviewing of other personnel as necessary; (d) establishing educational requirements; (e) making recommendations to the Medical Executive Committee for evaluation and observation and/or limiting of Clinical Privileges or Clinical Functions; and (f) periodically observing 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.

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.(2) below shall be required.

(2) Quorum: Voting Requirements

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

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, standing Committees described in these Bylaws, and special committees created as described in these Bylaws. 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 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 the Medical Executive Committee. Chairmen of all Medical Staff Committees and all members of the Medical Executive 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.

Notwithstanding any other provision of this Article X, until such time as the Medical Staff attains ten (10) Staff Members who are eligible to vote, the duties and functions of all Staff Committees shall be performed by 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 resigns or is removed from the Committee. The terms of Medical Executive Committee members and Committee members serving on Committees in his/her capacity as a Staff or Department Officer shall coincide with such 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) Infection Prevention and Control Committee;

(c) Joint Conference Committee;

(d) Medical Records Committee;

(e) Pharmacy and Therapeutics Committee;

(f) Quality Management Committee;

(g) Utilization Review Committee;

(h) Limited License Professionals and Allied Health Professionals Committee; and

(i) Any two (2) of the individuals identified in Article XI.C. 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

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 conducting 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 the voting Committee members (whether present or not).

(7) Special E-Meetings

a) With the exception of Committees and actions of Committees listed in Article X, A., 7) b) below, Special E-Meetings of any Committee may be called by the Chairman of the applicable Committee for the purpose of submitting an issue(s), including resolutions, policies or rules ("Committee Action") to vote by the Committee.

b) Special E-Meetings may not be called by the following Committees:

i) Medical Executive Committee: unless deemed urgent by the Chief of Staff, but in no event for the purpose of considering peer review issues or corrective action;

ii) Joint Conference Committee;

iii) Quality Management Committee; and

vi) Limited License Professionals and Allied Health Professionals Committee: for the purpose of considering peer review issues or corrective action.

c) Notice of the proposed Committee Action will be provided in writing to all members of the Committee who are eligible to vote at least three (3) business days prior to the Special E-Meeting (the "E-Meeting Notice").

d) Committee members eligible to vote may at any time before 5:00 p.m. on the fourth (4th) business day from the date of the E- Meeting Notice: vote to approve the Committee Action; or vote not to approve the Committee Action; or vote for the Chairman to call a special meeting (in person) for the purpose of considering the Committee Action.

e) Each Committee member eligible to vote is entitled to cast one (1) vote by submitting his/her vote as follows:

i) Delivering his/her written vote to the Director, Medical Staff Services (the "MS Services Director"); or

ii) Transmitting his/her written/typed vote by e-mail or by fax to the MS Services Director, provided that the Committee member receives confirmation from the MS Services Director or his/her designee that the Committee member's electronically transmitted vote was received.

f) Only votes submitted in compliance with Article X, A., 7) d) and e) above will be counted.

g) Except as provided below, at least thirty-three and one-third percent (33 1/3%) of the Committee members eligible to vote must submit votes through a Special E-Meeting ("E-Meeting Quorum").

h) The proposed Committee Action will pass by the affirmative vote of a majority (50% + 1) of the votes submitted.

i) The Chairman of the Committee will call a special meeting (in-person) if: The E-Meeting Quorum is not met; or if the E-Meeting Quorum is met, but more than ten percent (10%) of the Committee members who submit votes request a special meeting (in person) to consider the proposed Committee Action, even if the proposed Committee Action also receive the required votes for adoption. If a special meeting (in person) is called, unless the Committee member directs otherwise, a vote submitted in response to the Special E-Meeting will be counted and a Committee member may not submit a vote during the special meeting.

(8) Executive Sessions

Any Committee may meet in executive session, with only voting members present, upon the affirmative vote of a majority of the voting members present. Provided however, the Chief Medical Officer, the CEO and the Hospital Administrator may attend open and Executive Session portions of all Committee meetings.

B. Medical Executive Committee

(1) Composition

The Medical Executive Committee shall consist of the Officers of the Staff, the Department of Surgery Chairman, if any, and the Department of Medicine Chairman, if any. 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) attend meetings of the Committee on an ex-officio basis, without a vote. The CEO, Medical Director (Chief Medical Officer) and the Administrator may attend all parts of meetings, including any executive session(s). A member of the staff of Medical Staff Services may attend the meetings for the purpose of preparing minutes of the meetings.

(2) 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;

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

(h) Reviewing the qualifications, performance 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, Policies and Rules and Regulations and making recommendations to the Bylaws Committee, the Medical Staff and Board regarding revisions to the same as may be necessary for the proper conduct of the Staff consistent with these Bylaws;

(j) Proposing, adopting, and presenting for Board approval provisional amendments to these Bylaws which the Committee, in its discretion, determines are needed to address any urgent matter or issue, if the Committee determines that following the regular procedures for the amendment of these Bylaws will not appropriately address the urgent matter or issue;

(k) Immediately notifying the Staff of any provisional amendment proposed and adopted by the Committee;

(l) 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;

(m) Taking reasonable steps to develop continuing education activities and programs for the Staff;

(n) 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;

(o) Reporting to the Staff at each regular Staff meeting;

(p) Assisting in the obtaining and maintaining of accreditation;

(q) 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;

(r) Making recommendations to the Board regarding proposed Board actions that affect the Staff as a whole or individual members thereof;

(s) 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

(t) Reporting appropriate matters and making recommendations to the Board at each regular meeting.

(3) 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.

(4) 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.

C. Bylaws Committee

(1) Composition

The Bylaws Committee shall consist of at least three (3) 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, C.(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.

D. Infection Prevention and Control Committee

(1) Composition

The Infection Prevention and Control Committee shall consist of at least one (1) Staff Member eligible to vote (one (1) 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), and one (1) representative of Administration (appointed by the Administrator). Representatives of other clinical Departments 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.

E. 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 two (2) members of the Board appointed by the Chairman of the Board and two (2) members of the Medical Executive Committee appointed by the Chief of Staff. 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 the resolution of conflict between the Medical Executive Committee and the Staff, 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 also 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 all members of the Joint Conference Committee, and no business may be transacted by less than the affirmative vote of three (3) members of this Committee. All Committee members may vote.

F. Medical Records Committee

(1) Composition

The Medical Records Committee shall consist of at least three (3) Staff Members eligible to vote appointed by the Chief of Staff, with representatives from Hospital Nursing Services, Medical Records and Administration.

(2) Duties

The duties of the Medical Records Committee shall include:

(a) Reviewing medical records for their timely completion;

(b) Assuring that medical records reflect the admission data, condition of the patient at the time of discharge, admitting and final diagnosis, results of the history and physical examination, 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;

(c) Reviewing summary information regarding the timely completion of all medical records;

(d) 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;

(e) Notifying Practitioners regarding deficiencies in medical records when appropriate; and

(f) Requesting the Medical Director (Chief Medical Officer) 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 not less than every other month, and shall report its activities to the Medical Executive Committee. The Medical Records Committee shall maintain minutes of its activities and written reports of all evaluations performed and actions taken.

G. Pharmacy and Therapeutics Committee

(1) Composition

The Pharmacy and Therapeutics Committee shall consist of at least three (3) Staff Members eligible to vote, 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.

H. Quality Management Committee

(1) Composition

The Quality Management Committee shall consist of at least three (3) members of the Active Staff. If the Medical Staff consists of Departments, the Chairman of each Department shall be members of the Committee. Appointments will be made by the Chief of Staff. Meetings will be attended by the Chief Medical Officer, 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) Duties

The Quality Management Committee shall make recommendations upon and approve the Performance Improvement/Patient Safety Plan and will consider other issues of Quality Management as needed. The Committee shall also 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) Responsibilities of the Committee 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 Chief of Staff 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 Chief of Staff 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.

(b) The Committee will monitor performance, safety, effectiveness and outcomes by service, Department (if applicable), and individual provider with Clinical Privileges and/or Clinical Functions. If applicable, the Committee will review surgical and other invasive procedures to improve the selection (appropriateness) and performance (effectiveness) of the procedures.

(c) The Committee will review reports of specimens removed during procedures for major discrepancy or pattern of discrepancies, between preoperative and postoperative (including pathologic) diagnoses. The Committee 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 Committee 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.

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

(e) The findings, conclusions, recommendations and actions taken will be maintained and submitted to the Medical Executive Committee detailing analysis of patient care.

(3) Assistance of Medical Officer and Accreditation/Process Improvement Staff

The Accreditation/Process Improvement Department staff and the Chief 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.

(4) Committee Action Not Required For Corrective Action

Action or consideration by the Quality Management Committee is not required, and neither this Article X, H, nor the Medical Staff Review Policy, establish, procedures which must be followed prior to the Chief of Staff or the Quality Management Committee 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 the Quality Management Committee or the Chief of Staff, 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 Chief of Staff may 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 Chief of Staff to request such initiation of investigation pursuant to the Medical Staff Bylaws.

(5) 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.

I. Utilization Review Committee

(1) Composition

The Utilization Review Committee shall be composed of at least three (3) Staff Members who are eligible to vote and who are appointed by the Chief of Staff 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 every other month and as needed. The Committee shall maintain minutes of its findings, proceedings, and actions and shall make a monthly report to the Medical Executive Committee.

J. Limited License Professionals and Allied Health Professionals Committee

1) Composition

The Limited License Professionals and Allied Health Professionals Committee shall consist of at least two (2) Active Staff Members, all of whom interact with Limited License Professionals and Allied Health Professionals on a regular basis, and at least one (1) Limited License Professional or Allied Health Professional.

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 revisions to the Manual, upon the request of the Board and for adoption by the Medical Executive Committee and approval by the Board;

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 Department;

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.

K. Assistance from Medical Director

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 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 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.

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 (14th) 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.

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, such automatic relinquishment 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) 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 as required by these Bylaws or the Hospital Authority Bylaws or Policies 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 and the Chief of Staff. 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 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. The Practitioner's Clinical 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 this Article XI, D.(4) 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 affects or could affect adversely the health or welfare of a patient or patients and/or 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 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 concludes presentation of evidence within time limits established by the Presiding Officer;

(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 one-half (1/2) of 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 or 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

When required by law or regulation, as amended from time to time, the Administrator shall report decisions to the Georgia Composite Medical Board and the NPDB. Such reporting shall be made in compliance with timeframes established by law and regulation.

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 actions against the Hospital Authority, 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, (F), 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 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 Provider submitted, collected or prepared by any Representative for the purpose of evaluating and reviewing Providers' 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 Provider 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 Provider 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 Provider who is or has been an Applicant for Staff membership and/or Clinical Privileges or Clinical Functions of the Staff or who did or does exercise Clinical Privileges or Clinical Functions 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 Provider 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 Clinical Functions;

(b) Periodic reappraisals for reappointment, Clinical Privileges, or Clinical Functions;

(c) Corrective action;

(d) Hearings and appellate reviews;

(e) Patient care audits;

(f) Utilization reviews; and

(g) Other Hospital Authority, Department, 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 Provider'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 Clinical Functions within the Hospital, a Provider:

(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, and/or to his or her exercise of Clinical Privileges or provision of Clinical Functions 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

(d) Individual Staff Members performing Department and Committee 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 or Committee 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 Bylaws and 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 of these Bylaws.

(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 Board. Notwithstanding Article XVI or any other provision of these Bylaws, the foregoing indemnification agreement may be unilaterally terminated or amended by the Hospital Authority on sixty (60) days' written notice to the Chief of Staff, 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 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. 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 majority vote of the Staff members present and eligible to vote at a meeting 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 Staff Members eligible to vote. Once any amendment has been proposed, notice of such proposed amendment shall be given, in writing, to all Staff Members who are eligible to vote at least ten (10) days prior to the 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 Staff Members present and eligible to vote.

A proposed amendment can be changed by two-thirds ($2/3^{rds}$) of the voting Staff Members present at the 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 Staff Members present and eligible to vote at a meeting at which a quorum is present. Amendments so approved shall be subject to approval or disapproval by the Board.

C. Provisional Amendment of Bylaws

(1) Authorization and Notice to the Staff

In the event that the Medical Executive Committee determines that there is an urgent matter or issue which requires the amendment of these Bylaws and that following the manner for amending these Bylaws described in Article XVI, B will not appropriately address the urgent matter or issue, the Medical Executive Committee shall be authorized to propose and adopt provisional amendment(s) to these Bylaws. Upon the adoption of

any provisional amendment to these Bylaws, the Medical Executive Committee shall immediately notify the Staff of the provisional amendment and the urgent issue or matter to be addressed by provisional amendment.

(2) Board Approval of Provisional Amendments

Any provisional amendment to these Bylaws which is adopted by the Medical Executive Committee shall be transmitted for consideration and approval by the Board at its next regularly scheduled meeting. The provisional amendment shall be effective as of approval by the Board.

(3) Consideration of Provisional Amendments by the Staff

Once any provisional amendment to these Bylaws has been proposed and adopted by the Medical Executive Committee and immediate notice of the provisional amendment has been given to the Staff as provided in Article XVI, C(1), the Staff Members who are eligible to vote shall, at the next regularly scheduled meeting of the Staff, consider the provisional amendment and either adopt the provisional amendment by a majority vote of the Staff Members present and eligible to vote or submit comments on the provisional amendment, if any, to the Medical Executive Committee and the Board.

(4) Consideration of Provisional Amendments by the Joint Conference Committee

In the event that the Staff Members eligible to vote disagree with the provisional amendment, the Board shall refer the matter to the Joint Conference Committee, and a meeting of the Joint Conference Committee shall be called as provided herein. After review of the comments, information, and documents submitted by the Staff and/or the Medical Executive Committee, the Joint Conference Committee shall make a recommendation to the Board regarding the provisional amendment, and the Board shall, taking into consideration the recommendation of the Joint Conference Committee, make a final decision as to whether or not to approve or reject the provisional amendment.

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. 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.

C. Amendment

Staff Policies shall be reviewed annually or more frequently as the need arises to promote quality patient care. Policy amendments shall require the majority of votes of members present at a meeting and eligible to vote 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 or Policies and Procedures 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. In case of a conflict between a Policy(ies) and the Hospital Authority Bylaws or Policies and Procedures, the Hospital Authority Bylaws or Policies and Procedures, as the case may be, shall prevail.

Approved by the
SGMC Berrien Campus Medical Staff
2/9, 2022

_____, Chief of Staff

Approved by
The Hospital Authority of Valdosta and
Lowndes County, Georgia
2-16, 2022

By: _____
Sam Allen, Chairman