MEDICAL BYLAWS, RULES, & REGULATIONS

PORTER HOSPITAL, INC.

MIDDLEBURY, VERMONT

MEDICAL STAFF

BYLAWS,

RULES & REGULATIONS

REVISION DATES:

Approved by Porter Hospital Board of Directors:	August 3, 2016
Approved by Medical Staff:	June 16, 2016

THIS COMPILATION SUPERSEDES ALL PREVIOUS EDITIONS
Porter Hospital, Inc.

Bylaws, Rules and Regulations
of the Medical Staff

MEDICAL BYLAWS, RULES, & REGULATIONS

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MEDICAL STAFF BYLAWS, RULES, & REGULATIONS

WHEREAS, the Medical Staff of Porter Hospital, Inc. is responsible for the quality of medical care in the hospital; and

WHEREAS, the Medical Staff must have principles and policies by which it functions; and

WHEREAS, the Board of Porter Hospital, Inc. has the ultimate authority for the governing of the hospital;

NOW THEREFORE, the Medical Staff and the Board do hereby agree as follows:

ARTICLE I
Definitions

Unless the context clearly requires otherwise, the following words or phrases shall, for the purposes of these Bylaws and Rules and Regulations, be defined as follows:

Section 1.01 BOARD - The word "Board" shall mean the Board of Directors of Porter Hospital, Inc., a Vermont non-profit corporation, having its principal place of business located at Middlebury, Vermont.

Section 1.02 EXECUTIVE COMMITTEE - The term "Executive Committee" shall refer to the Executive Committee of the Medical Staff, consisting of the President, Vice President, and Secretary/Treasurer of the Medical Staff; the chiefs of Emergency Medicine, Family Practice, Medicine, Women's Health, Pediatrics, Radiology and Surgery and the director of the Hospitalist Service.

Section 1.03 HOSPITAL PRESIDENT - The term "Hospital President" shall mean the President of Porter Hospital, Inc.

Section 1.04 MEDICAL STAFF - The term "Medical Staff" shall include all Doctors of Medicine, Osteopathy, Dental Surgery, Podiatric Medicine, and Dental Medicine and Allied Health Professionals privileged to attend patients at Porter Hospital, Inc.

Section 1.05 PHYSICIAN - The term "physician" shall mean both Doctors of Medicine and Doctors of Osteopathy.

Section 1.06 HOSPITAL - The term "Hospital" shall mean Porter Hospital, Inc., a non-profit corporation incorporated under the laws of the State of Vermont, and having its principal place of business at Middlebury, Vermont.

Section 1.07 MEDICAL STAFF PRESIDENT - The term "Medical Staff President" shall mean the President of the Medical Staff.

ARTICLE II
Name and Purpose

Section 2.01 NAME - The Medical Staff as an element of Porter Hospital, Inc. shall be known as the Medical Staff of Porter Hospital, Inc.

Section 2.02 PURPOSE - The Medical Staff of Porter Hospital, Inc. shall have as its objects the fulfillment of the following purposes:

(1) To serve as the primary means for accountability to the Board for the quality and appropriateness of the professional performance of the Medical Staff, and professional ethical conduct of its members and to strive toward assuring that the patient care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available;

(2) To initiate and maintain rules and regulations regarding the governance of the Medical Staff;

(3) To provide a means whereby problems of a medico-administrative nature may be discussed by the Medical Staff with both the Board and the Hospital President; and

(4) To encourage the continual education of the Medical Staff and the continual maintenance of a high level of professional standards.

ARTICLE III
Membership on Medical Staff

Section 3.01 ETHICS AND ETHICAL RELATIONSHIPS – Each member agrees that he/she shall:

(1) Abide by the generally recognized principles of medical ethics;

(2) Provide for continuous patient care, including both in-patient and out-patient care, when the member is not able to provide coverage by oneself;

(3) Delegate, in her/his absence, the responsibility for diagnosis or care of her/his patients only to a practitioner who is qualified to undertake this responsibility or who is adequately supervised;

(4) Seek consultation whenever necessary; and

(5) Disclose to patients the true identity of an operating surgeon or any other practitioner providing treatment or services.

Section 3.01(1) REQUIREMENTS OF STAFF MEMBERSHIP - As an express condition of her/his membership, each member of the Medical Staff shall:

(1) Provide her/his patients with care at the generally recognized professional level of quality and efficiency;

(2) Abide by the terms, conditions and procedures of these Medical Staff Bylaws Rules and Regulations, and by all other lawful bylaws, standards, policies, and rules and regulations of the Hospital;

(3) Consistently discharge such staff, clinical Department, committee, and Hospital functions for which he/she is responsible by staff category assignment, appointment, election, or otherwise;

(4) Prepare and complete in timely fashion the medical and other required records for all patients he/she admits or in any way provides care to in the Hospital;

(5) Fully cooperate with and participate in Hospital peer review activities as directed by the Medical Care Review Committee, the clinical Department Chief or otherwise;

(6) Participate in relevant continuing education, a record of which shall be maintained in the staff member's file and shall include a brief summary of the content, as well as the accrued hours;

(7) Be free of any significant physical, mental, or behavioral impairment that interferes with, or presents a substantial probability of interfering with, patient care, the exercise of privileges, the assumption and discharge of required responsibilities;

(8) Accept and participate in Medical Staff committee assignments made by the Medical Staff President in accordance with Sections 8.03 and 8.04;

(9) Engage consistently in cooperative working relationships with members of the Medical Staff and Hospital Employees;

(10) Agree to participate in the Organized Health Care Arrangement ("OHCA") as set forth in the Hospital's Joint Notice of Privacy Practices, comply with the health information policies and practices of the Hospital and OHCA and sign acknowledgements agreeing to abide by the terms of the Joint Notice of Privacy Practices, as may be submitted to the Medical Staff from time-to-time.

(11) The application fee for appointment or reappointment to the Medical Staff must be submitted by the applicant along with the application. Payment must be received before processing will begin. Application fees are non-refundable. If, for any reason, an applicant

withdraws their application or it is denied, no refund will be provided. It is important, therefore, for applicants to review the Medical Staff Bylaws and applicable policies before submitting an application to be sure they meet the basic requirements. The application fee schedule is determined by the Medical Executive Committee and available upon request from the Medical Staff Coordinator.

Section 3.02 QUALIFICATIONS FOR STAFF MEMBERSHIP

Section 3.02(1) MINIMUM THRESHOLD CRITERIA - All applicants who seek Staff membership, and every Staff member seeking an increase in his/her privileges, must, at the time of initial appointment or application, and continuously thereafter, demonstrate to the satisfaction of the Executive Committee and the Board that he or she satisfies: (a) the Minimum Threshold Criteria for Staff membership and (b) the Minimum Threshold Criteria for the Department(s) and/or the privileges being sought (if any).

The Minimum Threshold Criteria for Department and specific privileges are developed and updated from time to time by the applicable Department submitted to the Executive Committee for review and recommendation to the Board for approval. The Minimum Threshold Criteria for appointment to the Staff and maintenance of Staff membership are as follows:

(1) **Licensure**. A currently valid and unrestricted license to practice medicine, podiatry, or dentistry in the State of Vermont; provided, however, that if a practitioner's license is conditioned, he/she must provide evidence satisfactory to the Credentialing Committee, the Executive Committee, and the Board that the conditions imposed will not impact the practitioner's ability to exercise the privileges they have been granted or are requesting and the basis for conditioning the license does not demonstrate a failure to satisfy any of the qualifications for membership described in these Bylaws.

(2) **Sanctioned Provider**. Confirmation that the practitioner:

(a) is not under indictment or the subject of a criminal prosecution for, or has been convicted of: (i) any offense related to the delivery of an item or service under the Medicare or Medicaid programs or any program funded under Title V or Title XX of the Social Security Act (the Maternal and Child Health Services Program or the Block grants to States for Social Services programs, respectively), including without limitation, any offense described in subsection (a) or in subsection (b)(1), (2), or (3) of 42 U.S.C. §1320a-7, (ii) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service, (iii) fraud, theft, embezzlement, or other financial misconduct in connection with the delivery of a health care item or service, (iv) obstructing an investigation of any crime referred to in (i) through (iii) above, or (v) unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;

(b) has not been required or has not agreed to pay any civil monetary penalty (not including routine restitution) under 42 U.S.C.A. Section 1320a-7a or 1320a-8 except

pursuant to a settlement agreement with a federal or state governmental unit that specifies that such unit will not exercise its exclusion authority; or,

(c) has not been excluded from participation in the Medicare, Medicaid, or Maternal and Child Health Services (Title V) program, or any program funded under the Block Grants to States for Social Services (Title XX) program.

(3) **DEA Registration**. For practitioners applying for or holding privileges to prescribe Scheduled drugs, a valid and unrestricted controlled substance registration issued by the DEA.

(4) **Professional Liability Insurance**. Professional liability insurance covering the applicant in at least the minimum amount required by law, or such higher amount as may be determined by resolution of the Board after consultation with the Executive Committee, or such other evidence of financial responsibility as the Board may establish. If such insurance is maintained on a claims-made basis at any time during a Member's membership, purchase of tail insurance or prior acts coverage upon termination of such insurance so that incidents occurring during the period of Staff membership are covered.

(5) **Board Certification**.

(a) All applicants must be Board-certified or Board-eligible. Board-eligible applicants who are accepted onto the Medical Staff must achieve Board certification within 5 years of the date of completion of their training or within such lesser period of time after completion of training as is required by the applicable specialty board. Once acquired, board certification must be maintained by all members of the Medical Staff. If a member of the medical staff fails to achieve or maintain board certification in accordance with this Section he /she must present a plan for rectifying this deficiency to the Executive Committee. The Executive Committee may extend the period of time for attaining/regaining board certification or an exemption thereto in a manner and time-frame that the Executive Committee finds appropriate for the situation.

(b) Those Staff Members who were granted Staff membership prior to January 1, 1999 and have never been Board certified are considered grandfathered into the Board Certification requirement. Those who were certified at that time must maintain board certification.

(6) **Failure to Meet Criteria**. If an initial applicant does not satisfy the foregoing Minimum Threshold Criteria, his/her application will not be processed and the applicant will not have any rights to review, including without limitation, a fair hearing.

If an applicant does not satisfy the Minimum Threshold Criteria for one or more Departments and/or privileges for which they are applying, or if a Department to which he/she is applying or the privileges being sought is/are closed, that applicant does not qualify for membership in the

Department or for the privileges at issue, and his/her application with respect to that Department or those privileges will not be processed, and the applicant will not have any rights to review, including without limitation, a fair hearing.

3.02(2) ADDITIONAL QUALIFICATIONS - In addition to satisfaction of the Minimum Threshold Criteria as described in Section 3.02(1), every practitioners who seeks or holds Staff membership must, at the time of initial appointment and continuously thereafter, demonstrate, to the satisfaction of the Executive Committee and the Board, that he or she satisfies the general qualifications for membership and privileges as listed below:

(1) **Performance**. Professional education, training, judgement, individual character, experience and clinical results demonstrating a continuing current competence and ability to provide quality patient care services.

(2) **Health Status**. The ability to perform, or timely disclosure of the need and request for any accommodation reasonably necessary to enable the practitioners to perform, the essential functions of his/her appointment and Privileges.

(3) **Absence of Criminal History**. An applicant shall not have a history of criminal convictions, guilty pleas and pleas of nolo contendere to felony charges.

Section 3.02(3) ADMINISTRATIVE POSITIONS - Officers and other physicians or health professionals as listed in Section 1.04 in administrative positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges.

Section 3.02(4) MEDICAL STAFF COMPLEMENT - At the time the Executive Committee and the Board review an application for appointment to the Medical Staff, they may consider, without limitation, (1) the priorities of the Hospital, in terms of the current and projected needs of the targeted patient community; (2) the capacities of the Hospital, in terms of its current and projected facilities and personnel; and (3) the capabilities of the Medical Staff, in terms of its aggregate current and projected composition and qualifications. They may solicit a report from the Planning Committee of the Medical Staff which should address the collective staff opinions regarding: (1) the adequacy, both short and long term, of the level and number of services delivered within the applicable clinical Departments of the Medical Staff and (2) the adequacy of the facilities wherein those services are delivered.

An applicant to the Staff and an applicant for an increase in privileges does not qualify for membership and/or the requested privileges if (a) the Department to which the applicant is applying, or the privileges the applicant is seeking, is/are closed as a result of an exclusive agreement or action of the Board, (b) that applicant does not satisfy the Minimum Threshold Criteria for Staff membership set forth in this Section 3.02, and/or (c) that applicant does not satisfy the Minimum Threshold Criteria for the Department applied to and/or privileges being sought, if any.

Section 3.03 PROCEDURE FOR APPOINTMENT, REAPPOINTMENT, PROVISIONAL APPOINTMENT AND RESIGNATIONS

Section 3.03(1) GENERAL PROCEDURE - The Medical Staff, through its designated Departments, committees and officers, shall assist in the investigation, evaluation, and consideration of each application for appointment and reappointment to the Medical Staff, each request for modification of Medical Staff membership status or clinical privileges and any AHP or other individual who seeks to exercise clinical privileges or provide specified services in any Department of the Hospital and shall adopt and transmit recommendations thereon to the Board. The Medical Staff will define monitoring and evaluation of any given Medical Staff Member professional performance, i.e. ongoing professional practice evaluation and/or a focused professional practice evaluation. (See Medical Staff Peer Review Policy).

Section 3.03(2) APPLICATION FOR APPOINTMENT - Applicants to the Staff must request an application from the Hospital, which request must include a list of the applicant's specialties and subspecialties. If the applicant's specialties or subspecialties fall within a Department which has been closed to further applications by the Board, the Hospital President shall advise the applicant in writing (a) that no applications are being accepted for that Department, and (b) the date on which closure of the Department will be reevaluated by the Board, if any. If all or some of the privileges being sought by the applicant do not involve a closed clinical discipline, the Medical Staff Coordinator will forward an Application for Appointment packet to the applicant. The application, as prescribed in 18 V.S.A. § 9408a, will be the form used by the Council for Affordable Quality Healthcare (CAQH), or a similar nationally recognized form, in electronic or paper format.

(a) The Application shall include a statement that the applicant has received and read the Bylaws, and applicable Policies, Procedures and Rules and Regulations of the Hospital and the Bylaws and Rules and Regulations of the Medical Staff and that he/she agrees to be bound by all the provisions thereof if granted clinical privileges, and to be immediately bound by all the provisions thereof in all matters relating to consideration of his/her application without regard to whether or not he/she is granted appointment or clinical privileges. Each applicant must furnish complete information including but not limited to the following:

(i) Postgraduate training, including the name of each institution (whether or not a degree was ultimately awarded), degrees granted, program completed, dates attended, and names of practitioners responsible for the applicant's performance.

(ii) All medical, dental and other professional licenses or certifications ever held by the applicant, and DEA registration, with the date and number of each and all jurisdictions in which a health-related license has ever been held.

(iii) Specialty or sub-specialty board certification and re-certification status.

(iv) The names and contact information respecting professional liability insurance carriers providing coverage of the applicant during the past ten (10) years, evidence of current professional liability insurance coverage, and information on malpractice claims history and experience (suits filed, suits settled or adjudicated, summons filed and/or served ("claims")).

(v) The nature and specifics of any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, non-renewal or voluntary relinquishment (by resignation or expiration) of any (1) license or certificate to practice any profession in any state or country; (2) DEA or other controlled substances registration; (3) faculty membership at any medical or other professional school; (4) staff membership status, prerogatives and/or clinical privileges at any other hospital, clinic or health care institution; (5) clinical training; and (7) third-party payor (including Medicare and Medicaid) status.

(vi) Location of offices; names and addresses of other practitioners with whom the applicant is or was associated and inclusive dates of such association; and names and locations of any other Hospital, clinic or health care institution or organization where the applicant provides or provided clinical services with the inclusive dates of each affiliation.

(vii) Department assignment, staff category, and specific clinical privileges requested.

(viii) Any current felony charges pending against the applicant and any past charges including their resolution.

(ix) Applicant's acceptance of the scope and extent of the authorization, confidentiality, immunity and release provisions of these Bylaws and the Application.

(x) The names and professional addresses of three (3) individuals who have personal knowledge of the applicant's current clinical ability, ethical character, and ability to work cooperatively with others and who will provide specific written, substantive comments on these matters upon request from Hospital or Staff authorities. The individuals providing references must have acquired their knowledge through recent observation of the applicant's professional performance over a reasonable period of time, and at least one reference must have had organizational responsibility for supervision of the applicant's performance (e.g., Training Program Director, Department Chief).

(xi) A current picture hospital ID card or other valid picture ID issued by a state or federal agency (e.g., driver's license or passport)

(b) The applicant shall have the burden of producing the information requested by the Application and any information deemed appropriate by the Hospital, the Staff and/or the Board, for the proper evaluation of his or her experience, training, competency, character, ethics and health

status and all other qualifications, for resolving any doubts about such qualifications, and for satisfying any reasonable requests for information or clarification (including health examinations) made by appropriate Staff, Hospital, or Board authorities. The applicant will be notified no later than 30 business days after receipt of the application of any deficiencies on a completed application. The Hospital will notify the applicant regarding the status of a completed application no later than 60 days after receipt of the application and every 30 days thereafter until the Hospital makes a final Credentials determination concerning the provider per 18 V.S.A. § 9408a.

(c) By applying for appointment to the Medical Staff, each applicant:

(i) authorizes Hospital representatives to consult with others who have been associated with him/her or who may have information bearing on his/her competence, character and qualifications;

(ii) consents to Hospital representatives inspecting all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges requested;

(iii) releases from any liability all Hospital and Staff representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials;

(iv) releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith and without malice concerning the applicant's competence, professional ethics, character, physical and mental health as it relates to his/her ability to carry out and perform the clinical privileges requested, emotional stability, and other qualifications for Medical Staff appointment and clinical privileges;

(v) attests to the correctness and completeness of all information furnished;

(vi) signifies his/her willingness to appear for interviews in connection with his/her application; and

(vii) agrees to abide by the terms of the Bylaws, Rules, Regulations, Policies and Procedure Manuals of the Staff and those of the Hospital (if granted membership and/or clinical privileges), and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not membership and/or privileges are granted.

For purposes of this Section, the term "Hospital representative" includes the Board, its directors and committees; the Hospital President or his/her designee; Medical Staff Coordinator; the Medical Staff organization and all Medical Staff members, Departments and committees which have responsibility for collecting or evaluating the applicant's credentials or acting upon his/her

application; and any authorized representative of any of the foregoing.

Section 3.03(3) INVESTIGATION AND VERIFICATION

(a) The Medical Staff Coordinator will collect and verify, from original sources or through a recognized and reliable credentials verification organization and/or through an equivalent source such as, but not limited to, the American Medical Association, American Board of Medical Specialties, Educational Commission for Foreign Medical Graduates, American Osteopathic Association, and/or Federation of State Medical Boards, the education and training, licensure history, professional affiliations, board certification, DEA registration, and other qualification evidence submitted. The Medical Staff Coordinator will query the National Practitioner Data Bank and the List of Excluded Individuals and Entities maintained by the Secretary of the Department of Health and Human Services. The Medical Staff Coordinator will forward questionnaires to the references listed on the application (including Department Chiefs and/or Training Program Directors, as described in Section 3.03(2)(a)(x) above). In addition, the Medical Staff Coordinator will order a criminal history report, or the applicant will provide a criminal history report, at the discretion of the Hospital.

(b) In addition to the original source verification described above, the Medical Staff Coordinator will forward a questionnaire to the Medical Staff Office or its equivalent, at each institution, ideally, up to a total of three, where the physician currently holds or held Medical Staff privileges to request information relating to the applicant's practice and history at that facility.

The applicant will be responsible for providing copies of medical records requested by the Medical Staff Coordinator that did not otherwise accompany the application.

In the case of Teleradiology Staff, the Medical Staff Coordinator will obtain a copy of the references on file with the applicant's employer.

(c) If the Medical Staff Coordinator is unable to obtain any information necessary to verify the information contained on the application or requested of any party in connection with the Application or if there are unexplained gaps on the Application, the applicant will be so notified. Upon such notification, it is the obligation of the applicant to obtain the required information.

(i) If requested information is not received or verification is not accomplished within a timely manner, a second request will be sent to the original source.

(ii) If verification or receipt of information is not accomplished soon after second request is made, the applicant is notified of his/her obligation to assist with verification.

(iii) If verification or receipt of information remains incomplete one-hundred twenty (120) days after the initial request for information, the Application shall be

deemed voluntarily withdrawn by the applicant, and the applicant shall be provided notice of such determination.

(iv) Notwithstanding the foregoing, if the Credentials Committee receives credible evidence that an applicant cannot obtain medical records associated with a professional liability action against the applicant from another facility (such as a letter from the facility that states that they will not provide a copy of the record and will not enter into a Data Use Agreement), then the Executive Committee may, in its sole discretion, waive the requirement that the records be provided, deem the application complete, and proceed to process the application.

(d) Only applications for appointment that have been deemed complete will be processed as provided in Section 3.04 of these Bylaws.

Section 3.04 THE APPOINTMENT PROCESS.

(1) When an application has been deemed complete, the completed application and all supporting materials shall be transmitted by the Medical Staff Coordinator to the Chief of each Department in which the applicant seeks clinical privileges. The Department Chief(s) may consult with a member of the Department in the same subspecialty as the Applicant regarding the requested clinical privileges. As part of the process of reviewing the Application, the Department Chief may meet with the applicant to discuss the Application, the applicant's qualifications and the requested clinical privileges. If the Department Chief anticipates recommending that the Application or any requested privileges be denied, he/she shall first communicate with the applicant. The Chief of each Department in which clinical privileges are sought shall review the Application and its supporting documentation and forward to the Credentials Committee a written appraisal of the applicant's qualifications for appointment and clinical privileges requested.

(a) If the Chief of the Department or the applicant perceives a potential conflict of interest between the two parties, then either individual may request that the Executive Committee review the potential conflict of interest. If the Executive Committee, deems it appropriate, it will assign a member of the Department or undertake the duties described in Section 3.04(1) hereof.

(2) The Credentials Committee shall examine the evidence of the character, current licensure, relevant training and experience, current competence, and ethical standing of the applicant and shall determine whether the applicant has established that he or she meets all of the necessary qualifications for the category of Staff membership and the clinical privileges requested. If any member of the Committee has a question regarding an applicant or the contents of an application, the applicable Department Chief or designee under Section 3.04(1)(a) may be asked to attend the meeting at which that applicant is being considered. The Credentials Committee shall consider the Application at its next scheduled meeting after its receipt of the Application and shall make a written recommendation to the Executive Committee. The recommendation may be

that (a) the applicant be appointed to the Staff with the scope of clinical privileges requested, (b) the Application be deferred for further consideration, (c) the applicant be appointed to the Staff with some of the clinical privileges requested, or (d) the Application for Staff membership and privileges be denied. In the event that the report and recommendation of the Credentials Committee is delayed longer than sixty (60) days, the Chair shall advise the applicant in writing of the delay and the reason.

(3) At its next regular meeting after receiving the report of the Credentials Committee, the Executive Committee shall consider the Application and determine whether to recommend to the Board that the applicant provisionally be appointed to the Staff (excluding Honorary staff). Such action may be deferred a maximum of sixty days. All recommendations of appointment must also recommend the specific clinical privileges to be granted including any conditions attached thereto and the initial Department assignments. Any recommendation of the Executive Committee for the denial of Staff membership or the denial of any of the clinical privileges requested by the applicant shall entitle that applicant to the procedural rights described in Section 3.11. Recommendations for approval shall be forwarded to the Board.

(4) The Board shall consider the Application at its next regularly scheduled meeting after receipt of a recommendation from the Executive Committee. If the Board approves appointment of the applicant to the Staff and grants the privileges requested by the applicant, the applicant shall be appointed to the Staff category to which he or she has applied. If the Board's decision is to deny the applicant Staff membership or any of the clinical privileges requested by that applicant, the applicant shall be entitled to the procedural rights contained in Sections 3.13, 3.14 and 3.15 of these Bylaws.

(5) Written notice of the Board's final decision shall be provided by the Hospital President to the applicant, Executive Committee, the Credentials Committee, and the Chief of each Department concerned.

Section 3.05 REAPPOINTMENT

(1) Except as otherwise provided in this Section 3.05, members of the Staff and AHPs shall be appointed for a period of two years.

(2) At least six (6) months prior to the expiration of the appointment of a Member of the Staff, the Medical Staff Coordinator will send that Staff Member a reappointment application in a form approved by the Executive Committee asking that it be completed and returned, with all requested materials, to the Medical Staff Coordinator within 45 days from receipt.

If the Staff Member fails to timely return said material, the Medical Staff Coordinator will send, via Certified Mail, a final notice that if the Staff Member does not return the reappointment application and all requested information within two (2) weeks of the date of that letter, there may be insufficient time to process the application, and if the application is not processed in a timely manner, the Member's Staff membership will expire at the end of its current term. If a complete

application has not been returned to the Hospital prior to expiration of the Member's membership, such membership shall expire unless and until a complete application is received and processed as described herein. A practitioner who relinquishes his or her privileges pursuant to this Section 3.05(2) must reapply to the Staff as a new member if he or she wishes to practice at the Hospital.

(3) The Medical Staff Coordinator will collect information and verify the licensure, board certification, DEA registration, and other qualification evidence submitted.

(4) Except in the case of Teleradiology Staff members, the Medical Staff Coordinator will contact the Medical Staff Office or its equivalent and the appropriate Department Chair(s) at each institution where the physician then holds or held medical staff privileges to request information relating to the applicant's medical records history and quality statistics at that facility.

(5) If the Medical Staff Coordinator is unable to obtain any information necessary to verify the information contained on the Application or requested from any party as described above, if responses are incomplete, or if the Application contains unexplained gaps, the applicant will be so notified. Upon such notification, it is the obligation of the applicant to obtain the required information.

(a) Notwithstanding the foregoing, if the Medical Staff Coordinator receives credible evidence that an applicant cannot obtain medical records associated with a professional liability action against the applicant from another facility (such as a letter from the facility that states that they will not provide a copy of the record and will not enter into a Data Use Agreement), then the Executive Committee may, in its sole discretion, waive the requirement that the records be provided and proceed to process the application.

(6) When the Medical Staff Coordinator is in receipt of a completed application, the application shall be processed as provided in Section 3.05(8) of these Bylaws.

(7) By applying for reappointment to the Medical Staff, the applicant certifies the ongoing applicability of the attestations, releases, and agreements described in Section 3.02 of these Bylaws.

(8) Applications that have been deemed complete will be processed in the same manner as applications for initial appointment as more fully described in Section 3.04 of these Bylaws. For purposes of reappointment, an "adverse recommendation" by the Executive Committee or an "adverse action" by the Board as used in Section 3.04 means a recommendation or decision to deny reappointment, a requested change in Staff category, or Department assignment, or to deny or restrict requested Clinical Privileges. The terms do not include an automatic change in Staff category pursuant to Section 3.10(3) of these Bylaws. The terms "applicant" and "appointment" as used in Section 3.04 shall, in the reappointment context, be read respectively, as "Staff member" and "reappointment".

(9) Each recommendation concerning a Staff member shall be based upon the appointee's competence, professional performance, judgment and ethics, clinical and technical skills as indicated, in part, by the results of the Hospital's quality assessment and improvement and risk management activities, attendance at Medical Staff meetings and affairs, and compliance with the Hospital's Bylaws and applicable Policies, Procedures and Rules and Regulations the and Medical Staff's Bylaws, Rules and Regulations, and Policies and Procedures.

Section 3.06 MEMBER'S WITHDRAWAL - At any time a member shall have the right, by written notification to the Hospital President or the Medical Staff President of the Medical Staff, to withdraw his/her application for initial appointment or request for a change in staff category, increase or reduction in privileges, or reappointment, in which event there will be no final decision rendered and the request will be considered withdrawn.

Section 3.07 TIME PERIODS FOR PROCESSING - The time periods applicable to the Medical Staff Coordinator, Hospital, Staff, Staff Committees and Board that are provided for in Sections 3.04 and 3.05 are guidelines and are not directives which create any rights for a practitioners to have an application processed within these precise periods. If the provisions of Sections 3.13, 3.14 and 3.15 are activated, the time requirements provided therein govern the continued processing of the application.

Section 3.08 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES - A Staff member may, either in connection with reappointment or at any other time, request modification of his/her Staff category, Department assignment, or clinical privileges by submitting a written request to the Hospital President or the Medical Staff President or their designee on the prescribed form. A modification request will be processed in the same manner as an application reappointment if it occurs during the term of appointment or as a part of the reappointment application if the request occurs at that time.

Section 3.09 LEAVES OF ABSENCE AND RESIGNATIONS

(1) Requests for elective leaves of absence of up to one year (except for military service) from the Staff shall be made in writing to the Secretary of the Staff for transmittal to the Executive Committee and appropriate Department Chief(s) and may be granted to the appointee by the Executive Committee.

(2) No request for a leave of absence shall be considered until all obligations to the Hospital have been satisfactorily completed by the Staff member, including the practitioner's obligation to arrange for appropriate coverage of his or her patients during the period of absence.

(3) During the period of the leave, the Staff Member's clinical privileges, prerogatives and responsibilities will be suspended. The Medical Staff President shall inform the Board whenever any Practitioner takes a leave of absence.

(4) The Staff Member must, at least sixty (60) days prior to the termination of the leave, or may at any earlier time, request reinstatement by sending a written notice to the Executive Committee. If the Staff Member fails to request reinstatement during this time period, then upon the expiration of the Staff Member's leave of absence, the Staff Member shall be deemed to have voluntarily relinquished his Staff Membership. If the term of the leave exceeds six (6) months or if the applicant's appointment expires during the leave period, the request will be treated as a request for reappointment, and the request will be processed pursuant to Section 3.05 of these Bylaws. If the term of the leave is less than six (6) months and the requested reinstatement will occur during a reappointment cycle, the Executive Committee shall make a recommendation respecting the Member's reinstatement to the Board and the Board shall have final authority to approve or deny the reinstatement. The Member shall provide all information requested by the Executive Committee and/or the Board in connection with their consideration of his/her request for reinstatement.

(5) Any Member who wishes to resign from the Medical Staff must submit a letter of resignation to the Executive Committee and the Hospital President stating his/her request.

Section 3.10 REVIEW OF PROVISIONAL PRIVILEGES

(1) Except in the case of appointments to the Honorary Staff, all initial appointments to the Staff, all approvals of AHPs, and all increases in privileges shall be provisional for a period of one year from the date of appointment, approval, or grant of privileges. During the provisional period applicable to initial appointments to the Staff, Active Staff members shall not be eligible to hold any Medical Staff or Department office. The provisional period shall not in any other way affect Staff membership or the exercise of privileges.

(2) Provisional appointees and Members who have been granted an increase in privileges shall be assigned to a Department(s) where their performance shall be observed and evaluated by the Department Chief(s) or their representatives to determine the eligibility of such provisional appointee for regular Staff appointment and for exercising the clinical privileges provisionally granted to them.

(3) Within sixty (60) days of the conclusion of the initial 12-month provisional appointment period, the appropriate Department Chief shall review the practitioner profiles for each provisional Staff member within his/her Department, review other quality information pertaining to the provisional appointee's practice at the Hospital, and review information regarding meeting attendance and other evidence of discharge of the responsibility of Staff members generally and make a written recommendation to the Executive Committee respecting whether (a) the provisional appointee should be advanced to the Staff category in the Department to which s/he had applied or the provisional status of privileges shall be removed, as the case may be; (b) the practitioner does not have sufficient activity at the Hospital for the Department Chief to conclude the practitioner's provisional status in one year, so that the practitioner's provisional status shall be extended for up to one year; provided, however, that if, during the additional provisional period, the practitioner has insufficient activity at the Hospital for the Department Chief to conclude

the practitioner's provisional status, and the practitioner has been so notified and afforded the opportunity to submit information from another source, the practitioner's Staff appointment will then be considered to have been voluntarily relinquished at the end of that provisional period; (c) the provisional period should be extended for up to one additional year for reasons other than lack of activity; (d) the provisional period should be extended for up to one additional year with restrictions; or (e) the practitioner should not be advanced to the requested Staff category or the privileges at issue should be denied, as the case may be.

(4) The Executive Committee shall consider the recommendations of the Department Chief(s) at its next meeting following receipt of the Chief's recommendations and shall make one of the recommendations described in Section 3.10(3) to the Board. If the recommendation made by the Executive Committee is as described in Section 3.10(3)(e), the recommendation shall be deemed a recommendation not to re-appointment. A provisional member of the Staff whose appointment is so terminated or whose privileges are denied, shall have the rights accorded by Sections 3.13, 3.14 and 3.15 of these Bylaws.

(5) If the recommendation of the Executive Committee is as described in Section 3.10(3)(a), (b), (c), or (d) of these Bylaws, the Board shall consider the recommendation at its next meeting following receipt of the Executive Committee's recommendation. The Board may take any of the actions listed in Section 3.10(3) of these Bylaws. If the action taken by the Board is as described in Section 3.10(3)(e) of these Bylaws, then the action shall be deemed a termination of Staff appointment or denial of privileges, as the case may be, and the appointee shall have the rights accorded by Sections 3.13, 3.14 and 3.15 of these Bylaws. If the action taken by the Board is as described in Section 3.10(3)(a), (b), (c), or (d), the impacted practitioner shall be notified in writing by the Hospital President or his/her designee.

(6) Where a Staff appointee's provisional period or the provisional status of privileges has been extended by the Board, the process described in Section 3.10(3) through (5) shall be repeated upon conclusion of the extended provisional period.

Section 3.11 PROCEDURE FOR CORRECTIVE ACTION

(1) Whenever the activities or professional conduct, either within or outside of the Hospital, of any Medical Staff Member with staff privileges are considered: (a) to be detrimental to the standards, aims, rules or policies of the Hospital or Medical Staff, (b) to be reasonably likely to be detrimental to patient safety or to the delivery of quality patient care, (c) to be disruptive to the operations of the Hospital, or (d) to constitute an impairment to the community's confidence in the Hospital, corrective action against such Medical Staff Member may be requested by any officer of the Medical Staff, including the chief of any Department; by the Chairperson of any standing committee of the Medical Staff; by the Hospital President; or by the Board. All requests for corrective action shall be made in writing to the Medical Care Review Committee and shall describe the specific activities or conduct which constitutes the grounds for the request. Upon receipt of a request for corrective action the Chairperson of the Medical Care Review Committee shall immediately notify the Chief of the Department of the Medical Staff

member, as well as the Medical Staff President. The MCRC will respond in accordance with its Operational Plan. The Department Chief shall investigate the allegations as described in Section 3.11 (3) below. Both the MCRC and Department Chief will present their findings to the MEC within 10 days.

(2) Whenever a request for corrective action involves primarily issues of a medical staff member's behavior, including without limitation, any claims of harassment or sexual harassment, the request for corrective action shall be forwarded to the Executive Committee directly without review by the Medical Care Review Committee, unless such review is requested by the Executive Committee.

(3) Within 10 days after the Department Chief's receipt of the request for corrective action, or sooner as needed to maintain patient care, she/he shall investigate the allegations contained in the request and make a report of her/his investigation to the Executive Committee. Before the Department Chief makes such report, he/she shall give the affected Medical Staff Member an opportunity for an interview with the Department Chief. At such interview, the Medical Staff Member shall be informed of the general nature of the concerns raised, and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing and shall be preliminary in nature. None of the procedural rules provided in these Bylaws with respect to hearings shall apply to interviews provided pursuant to this subparagraph. A summary of any interview provided pursuant to this subparagraph shall be made by the Department Chief and included with her/his report to the Executive Committee.

(4) Within 14 days of its receipt of the report of a Department Chief's investigation, or sooner as needed to maintain patient care, the Executive Committee shall take action upon the request. If the corrective action involves a reduction or suspension of clinical privileges or suspension or expulsion from the Medical Staff, the affected Medical Staff Member shall be permitted to make an appearance before the Executive Committee prior to its taking any final action on such request. This appearance shall not constitute a hearing and shall be preliminary in nature. None of the procedural rules provided in these Bylaws with respect to hearings shall apply to such an appearance. A report of such appearance shall be prepared by the Executive Committee.

(5) Based on its review, the Executive Committee may recommend that the Board take the following actions: reject or modify the request for corrective action; issue a warning, a letter of admonition, or a letter of reprimand; impose terms of probation or a requirement for consultation; reduce or eliminate privileges; terminate, modify or sustain an already imposed summary suspension of clinical privileges; or suspend or revoke Medical Staff membership.

(6) Any recommendation by the Executive Committee for reduction, suspension or revocation of clinical privileges or for suspension or expulsion from the Medical Staff shall entitle the affected Medical Staff Member to the procedural rights provided in Sections 3.13, 3.14 and 3.15 of these Bylaws.

(7) The Chairperson of the Executive Committee shall promptly notify the Hospital President in writing of all requests for corrective action received by the Executive Committee and shall keep the Hospital President fully informed of all action taken in connection therewith. After the Executive Committee has made its recommendation in a matter, the procedure to be followed shall be as provided in Sections 3.13, 3.14 and 3.15 of these Bylaws.

(8) All actions of the Executive Committee on a request for corrective action shall be referred to the Board for final action; provided, however, that in instances in which a Medical Staff Member is entitled to exercise the procedural rights provided in Sections 3.13, 3.14 and 3.15 of these Bylaws, the Board shall not take final action until the Medical Staff Member has exercised or waived said rights.

(9) If corrective action is to be taken against a Department Chief, then the Executive Committee shall fulfill the review responsibilities granted to the Department Chief under this Section.

Section 3.12 SUSPENSION AND REVOCATION - The Hospital President, or his or her designee, and the Medical Staff President, or his or her designee, shall jointly have the responsibility of initiating the suspension of staff privileges of any member of the Medical Staff. A suspension may lead to a determination by the Board revoking or limiting staff privileges and staff membership. If staff privileges and membership are revoked, the individual may not reapply for membership on the Medical Staff for the period of two (2) years from the date of the decision, except where such revocation has occurred as a result of a staff member's absence from staff meetings and/or Department meetings as provided in Section 9.03. A suspension or revocation under this section applies to both staff privileges and staff membership. Staff privileges and staff membership are coextensive. An individual cannot have staff privileges without staff membership and vice versa.

Section 3.12(1) SUMMARY SUSPENSION - - The Hospital President, or his or her designee, and the Medical Staff President, or his or her designee, may summarily suspend the staff privileges and membership of a member of the Medical Staff if, in their joint judgment, such action is necessary to avoid imminent danger or immediate and irreparable harm to the suspended individual's patients who remain in the Hospital, to existing or prospective patients who may be admitted to the Hospital, or to the health of any individual. Concurrent with any summary suspension, the Medical Care Review Committee will convene to address, in executive session, the concerns which prompted the suspension, in accordance with the Operational Plan of the Medical Care Review Committee. Its findings shall be presented to the Executive Committee, which will then act in accordance with Section 3.12(6). The length and terms of such suspension shall be within the discretion of the Executive Committee acting in conjunction with the Hospital President and the Medical Staff President.

Section 3.12(2) AUTOMATIC SUSPENSION

(a) If a staff member fails to complete medical records or fails to sign a properly

completed patient's chart within fifteen (15) days after discharge of her/his patient, she/he shall be given written notice of that omission. If within two (2) weeks after such notice is given, the member still has not corrected her/his omission, her/his staff privileges shall be suspended until such time as her/his charts and medical records have been brought up to date, and shall be assessed a fine, the amount of which is to be set by Medical Staff policy. The fine must be paid to the Medical Staff Treasurer within thirty days. In the event that the fine has not been paid before the staff member's next application for reappointment is due, the staff member shall be denied reappointment until all outstanding fines are paid in full. Fines may be waived in the event that a physician who is going to be absent from campus has notified Medical Records prior to their absence.

(b) Action by the State Board of Medical Practice or any comparable licensing body revoking or suspending a Medical Staff member's license shall automatically result in suspension of all staff privileges.

(c) A staff member whose DEA Registration is revoked, suspended or surrendered for any reason shall automatically be suspended from all staff privileges.

Section 3.12(3) OTHER SUSPENSIONS - If for reasons other than those set forth in Sections 3.12(1) and (2), sufficient cause is found for the privileges of an individual to be suspended, the Hospital President, or his or her designee, shall send that individual a letter explaining why the privileges of the individual have been suspended, and stating a time, place and date (no later than five (5) days from the date of the notice) at which a hearing shall be held on the proposed suspension. The hearing shall be held before the Executive Committee in accordance with the provisions of Sections 3.13 through 3.15 herein. No suspension under this section shall become effective until after the opportunity for hearing has passed pursuant to Section 3.13. The Executive Committee shall make a recommendation to the Board as to the length and terms of such suspension. An appeal from the decision of the Executive Committee shall not serve to postpone the time and date at which such suspension is to become effective.

Section 3.12(4) FAILURE TO COMPLY WITH BYLAWS, RULES AND REGULATIONS - The failure of a member of the Medical Staff to comply with these Bylaws and Rules and Regulations shall constitute grounds for the suspension of the privileges of an individual as set forth in Section 3.12(3).

Section 3.12(5) PATIENT CARE COVERAGE - Concurrent with a suspension under this Section, the Medical Staff President shall be responsible for providing alternative medical coverage for the suspended individual's patients in the Hospital. The Medical Staff President shall first consult with the suspended individual's patients regarding the selection of alternative medical coverage.

Section 3.12(6) EXECUTIVE COMMITTEE RECOMMENDATION - As soon as possible after any summary or automatic suspension, a meeting of the Executive Committee shall be convened to review and consider the action taken. The Executive Committee may

recommend modification, continuation, or termination of the terms of the summary suspension.

(a) Unless the Executive Committee recommends the immediate lifting of the suspension and cessation of all further corrective action, the Medical Staff Member shall be entitled to the procedural rights provided in Section 3.13, 3.14 and 3.15 of these Bylaws.

(b) All determinations concerning summary suspension are subject to review and final action by the Board; provided, however, that, in instances in which the Medical Staff Member is entitled to exercise the procedural rights provided in Sections 3.13, 3.14 and 3.15 of the Bylaws, final Board action shall not be taken until that physician has exercised or waived her/his rights under those sections. The determination of the Executive Committee on the summary suspension shall remain in effect pending a final decision by the governing body.

Section 3.13 HEARING IN EVENT OF SUSPENSION - Upon the suspension or reduction of privileges of a member of the Medical Staff, the Hospital President shall send to the member involved a letter which contains (a) a statement of the reasons for the suspension, (b) a statement of the member's right to request a hearing within thirty (30) days, and (c) a copy of her/his rights at the hearing under this Section and Section 3.14. If a hearing is requested, the hearing shall be scheduled as soon as reasonably possible but in any event within 30 days. The notice of hearing shall state the time and place of the hearing and provide a list of witnesses (if any) expected to testify at the hearing in support of the decision. Prior to the hearing, the member shall notify the Hospital President of all witnesses (if any) she/he expects to testify on her/his behalf. The hearing shall be conducted before a hearing committee selected by the Executive Committee ("the hearing committee") in accordance with the procedures set forth in Section 3.14 herein. No member of the hearing committee may be in direct economic competition with the member whose privileges have been suspended. The member may waive her/his right to a hearing, and in that event, the Board may take final action on her/his suspension.

Section 3.14 CONDUCT OF HEARING - SUSPENSION - A majority of the members of the hearing committee shall be present when the hearing takes place, and no member may vote by proxy. An accurate record of the hearing must be kept by either a court reporter, stenographic notes or an electronic recording unit. The member requesting the hearing shall be required to be present. If the member fails to attend the hearing, she/he shall have been deemed to have waived her/his rights to participate in the hearing. The hearing may be postponed only for good cause shown, and such decision shall be in the sole discretion of the hearing committee. The member may be represented by any person or legal counsel, and she/he may present testimony to rebut any of the reasons given for the suspension or revocation of privileges. The hearing committee shall appoint one of its members to serve as Chairperson, and she/he shall preside over the hearing and determine the order of procedure during the hearing. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or the presentation of evidence; however, all witnesses shall testify under oath. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make

evidence inadmissible in a civil or criminal action. The Hospital President shall appoint one person who may be an attorney to examine witnesses and to present facts in support of the suspension or proposed revocation of privileges. The burden of proof shall be upon the Hospital President or Medical Staff President to show that a reason exists for the suspension or revocation of the member's staff privileges. The burden shall then be on the member to rebut such facts with an appropriate showing that the decision lacked any factual basis or that such basis or was arbitrary, capricious or unreasonable.

The member shall have the right to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any relevant matter, to challenge any witness, and to rebut any witness. If the member does not testify in her/his own behalf, she/he may be called and examined as if under cross examination. The hearing committee shall be entitled to recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence. The member is permitted to submit a written statement at the close of the hearing.

Within a reasonable time, not to exceed 30 days after the close of the hearing, the hearing committee shall make a written report and recommendation and forward the same together with the hearing record and all other documentation to the Board. The report may recommend reinstatement, reinstatement under terms and conditions, suspension for a set period of time under certain terms and conditions, or revocation of staff privileges and membership. Written notice of the hearing committee's decision shall be promptly provided to the member by the Hospital President, and, if adverse, shall specify the member's rights to appellate review as set forth in Section 3.15.

Section 3.15 APPELLATE REVIEW AND FINAL ECISION - SUSPENSION - The member shall also be accorded the right to appellate review by the Board of the decision of the hearing committee. Thereafter, the Board shall make a final decision regarding the status of the member's staff privileges and membership.

Section 3.15(1) APPELLATE REVIEW - Within twenty (20) days after the date of the written notice of a final adverse decision by the Board, the member may, by written notice to the Board delivered through the Hospital President, request review of the matter by the Board. The member shall be entitled to request that the review be held on the record on which the adverse decision was based, as supported by her/his written statement, or she/he may request that oral argument be held as part of the review. If a request for review has not been received within twenty (20) days after the receipt of the notice, the member shall have waived her/his right to the same, and the adverse decision shall become effective.

After receipt of a request for appellate review, the Board shall schedule a date, time, and place for oral argument, if such has been requested, and shall, through the Hospital President notify the member in writing. The date of the oral argument shall not be more than fifteen (15) days from the date of receipt of the notice for request for appellate review.

The appellate review shall be conducted by a committee appointed by the Board of not less than three (3) members. The member shall have access to the report and record of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse decision. The committee appointed by the Board shall review the record created at the hearing, shall consider any written statements provided to it, and shall listen to any oral argument presented. Matters not raised during the original hearing shall not be introduced during the appellate review. After the oral argument, the committee shall make a final decision within a reasonable time not to exceed fifteen (15) days and notify the member of that decision in writing.

Section 3.15(2) FINAL DECISION - At a regularly scheduled meeting after the conclusion of appellate review, the Board shall finalize the decision made by its committee. In the event of a revocation of membership and staff privileges, the Medical Staff Member shall not be entitled to reapply for membership on the Medical Staff for a period of two (2) years from the date of that decision.

Section 3.16 CRITERIA FOR PROFESSIONAL AND PEER REVIEW DECISIONS - Any and all actions described in Sections 3.04 and 3.05 (final decision on application or re-application for staff membership and privileges), 3.11 (corrective action) and 3.12 (suspension) shall be taken only if the following criteria is met:

(a) The action is reasonably believed to be in furtherance of quality health care;

(b) A reasonable effort to obtain all pertinent facts of the matter has been made;

(c) The notice and hearing procedures, except as pertains to the initiation of a suspension, as set forth in these Medical Staff Bylaws have been followed; and

(d) Such action is reasonably believed to be warranted based on the facts known and pursuant to paragraphs (b) and (c) above.

Section 3.17 STATE AND FEDERAL REPORTING REQUIREMENTS - The Board shall be responsible for meeting state and federal requirements for reporting professional review actions taken against Medical Staff members, including the requirements of the Federal Health Care Quality Improvement Act of 1986 (42 U.S.C. Section 11111 et. seq.).

ARTICLE IV
Division of the Medical Staff

Section 4.01 THE MEDICAL STAFF - The Medical Staff shall be divided into Active Medical Staff, Consulting Medical Staff, Affiliated Medical Staff, Honorary Medical Staff, Dental Staff, Podiatric Staff, and Allied Health Professional groups. Each active and consulting staff member shall designate one clinical Department as a major affiliation for organizational purposes. Privileges in multiple Departments may be requested. The Bylaws and Rules and

Regulations apply to all members of the Medical Staff.

All requests for change of staff category shall be discussed with the Department Chief of the appropriate clinical Department in advance of any request to the Executive Committee. The Executive Committee, in conjunction with the Department Chief, will evaluate the request and recommend that the Board either grant or deny the requested change. The Medical Staff President shall notify the staff member seeking a change in staff category of the Executive Committee's recommendation. The Board shall make the final decision to grant the requested change in staff category. In the event a change of category is denied by the Board, the staff member requesting the change is entitled to hearing procedures as outlined in Section 3.06.

Section 4.02 THE ACTIVE MEDICAL STAFF - The Active Medical Staff shall consist of those physicians who have been appointed by the Board upon recommendation by the Executive Committee and who:

(a) admit patients to Porter Hospital, perform surgery at Porter Hospital or perform their professional services, such as hospital medicine, radiology, anesthesiology or emergency medicine primarily at Porter Hospital or in a Porter Hospital Practice;

(b) admit patients to Helen Porter Healthcare and Rehabilitation Center; and/or

(c) provide outpatient care to patients in Addison County and have their professional services reviewed through a recognized third-party process upon which the Medical Staff has determined it will rely for reappointment in accordance with Article III, Section 3.03.

Members of the Medical Staff shall have appropriate delineated privileges within the Departments to which they are appointed. Members of the Active Medical Staff shall be eligible to vote, serve on Medical Staff committees and hold Medical Staff office. Medical staff office shall be considered to include: committee chairs, department chiefs and Medical Executive officer.

Section 4.03 CONSULTING MEDICAL STAFF - The Consulting Medical Staff shall consist of those physicians who have been appointed by the Board on recommendation of the Executive Committee to serve as consultants who may admit patients and who intend to provide their services to the Porter Hospital community on a regular basis. Membership on the Consulting Medical Staff shall not render the member ineligible for membership on the Active Medical Staff. Members of the Consulting Medical Staff shall have delineated privileges as recommended by the chief of the appropriate clinical Department in the treatment of all patients falling within the Department to which they are appointed. Members of the Consulting Medical Staff may serve on Medical Staff Committees. If a physician does not have a primary affiliation with another hospital or qualify for Affiliated Staff, he/she shall join the Active Medical Staff.

Section 4.04 AFFILIATED MEDICAL STAFF - The Affiliated Medical Staff shall consist of physicians qualified for staff membership who practice at Porter Hospital for fewer

than 90 days per any one-year period, either as locum tenens, ER physicians or as approved by the Medical Staff Executive Committee. They shall be appointed by the Board on recommendation of the Executive Committee and shall have delineated privileges within a specific clinical Department. Members of the Affiliated Medical Staff may serve on Medical Staff committees.

Section 4.05 HONORARY STAFF - The Honorary Medical Staff shall consist of physicians who are not active in the Hospital and who are honored by emeritus positions. These may be physicians who have retired from active Hospital service or physicians of outstanding reputation. The Honorary Medical Staff shall be appointed by the Board on recommendation of the Executive Committee.

Section 4.06 DENTAL STAFF - The Dental Staff shall consist of dentists who are graduates of recognized and approved dental schools and who are licensed to practice dentistry in the State of Vermont. Dental surgeons shall be required to have completed an internship in an approved hospital or to have had other postgraduate training and experience acceptable to the Credentials Committee. Dental surgeons appointed to the Dental Staff shall have delineated privileges regarding specific procedures as recommended by the chief of surgery and the Executive Committee. Oral Surgeons may apply for Active Medical Staff status in the Department of Surgery. They may admit patients without medical problems and perform the medical history and physical examination on those patients. Members of the Dental Staff may vote and serve on Medical Staff Committees.

Section 4.07 PODIATRIC STAFF - The Podiatric Staff shall consist of podiatrists who are graduates of recognized schools of podiatry and who are licensed to practice podiatry in the State of Vermont. Podiatrists shall have completed a residency, be board eligible, and have experience acceptable to the Credentials Committee. Podiatrists appointed to the Podiatric Staff shall have delineated privileges regarding specific procedures as recommended by the chief of surgery and the Executive Committee. They shall abide by the rules and regulations set forth in Section 12 of the Rules and Regulations. Members of the Podiatric Staff may vote, hold Medical Staff office and serve on Medical Staff committees.

Section 4.08 ALLIED HEALTH PROFESSIONAL STAFF - The Allied Health Professional Staff shall consist of individuals who are not physicians but who have such specialized training and skills as to make them valuable in the care of patients within the Hospital. They shall be permitted to admit and care for patients only under the supervision/collaboration of an Active Staff physician. The scope of activity and degree of responsibility to be taken shall be determined for each individual by the Department Chiefs on the basis of training and experience. They shall be subject to all the Rules and Regulations of the Hospital and the Medical Staff. The supervisory/collaborating physician shall be responsible for the actions, duties, qualifications and quality of work of his/her respective Allied Health Professional assistants. An applicant for membership on the Allied Health Professional Staff shall be legally licensed in his/her respective field by the State of Vermont, if licensure is available. Members of the Allied Health Professional Staff shall participate in activities of the

Departments to which they are credentialed. Members of the Allied Health Professional Staff may vote and may serve on Medical Staff committees.

ARTICLE V
Clinical Departments

Section 5.01 DEPARTMENTS - The Medical Staff shall practice within one or more of the following Departments: Medicine, Surgery, Women's Health, Radiology, Pediatrics, Emergency Medicine, Family Practice, and such other Departments as the Active Medical Staff may designate. Members of the Medical Staff shall not be restricted to practice in one Department if delineated privileges are requested and granted in multiple Departments by the respective clinical Department Chiefs. Members of each Department shall meet regularly, at a frequency to be determined by a majority vote of its members. Members of a Department are required to attend a minimum number of Department meetings, to be established by a majority vote of its members.

Section 5.02 CHIEF OF STAFF - The Medical Staff President shall function as Chief of Staff. He/she shall be responsible for the functioning of the Medical Staff within the clinical organization of the Hospital and shall supervise the work of the Medical Staff.

Section 5.03 ORGANIZATION OF DEPARTMENTS - Appointments and re-appointments to the different Departments requested shall be made by the Board. Members shall remain with delineated privileges for the duration of their term of appointment. After biennial reappointments have been made, the member or members of each Department shall organize so as to ensure proper operation of the Department. A chief of Department-elect shall be elected by the primary members of each Department before the Annual Meeting of the Medical Staff. After biennial reappointments have been made, his/her term as Department Chief shall commence, and he/she shall be responsible to the chief of Staff and shall have general supervision over the clinical work of his/her Department. In the event that a chief of Department-elect fails to be reappointed, the active staff members of each Department shall elect a chief of Department from the Active Staff membership within the Department.

Section 5.04 DEPARTMENT CHIEFS

Each Department Chief shall be a member of the Active staff and shall be primarily responsible to:

(a) oversee clinically related activities of the Department;

(b) oversee administratively related activities of the Department, unless otherwise provided by the Hospital;

(c) provide continuing surveillance of the professional performance in the Department, unless otherwise provided by the Hospital;

(d) recommend to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the Department;

(e) recommend Clinical Privileges for each member of the Department;

(f) assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or the Hospital;

(g) assist in the integration of the Department into the primary functions of the Hospital;

(h) assist in the coordination and integration of interdepartmental and intradepartmental services;

(i) assist in the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

(j) recommend appropriate staffing levels to enable appropriate provision of care, treatment and services;

(k) assist in the continuous assessment and improvement of the quality of care, treatment, and services;

(l) assist in the maintenance of quality control programs, as appropriate;

(m) recommend appropriate levels of space, equipment and other resources required by the Department;

(n) determine the qualifications and competence of Allied Health Providers who provide patient care, treatment and services; and,

(o) confirm participation in orientation and continuing education of all persons in the Department.

ARTICLE VI
Clinical Privileges

Section 6.01 CLINICAL PRIVILEGES – GENERAL

(1) Except as specifically provided herein, every practitioner practicing at the Hospital by virtue of Staff appointment or approval as an AHP shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Board.

(2) Periodic reevaluation of the clinical privileges granted to a practitioner and the increase or curtailment of such privileges shall be based upon direct observation of care provided, review of the records of patients treated in this or other hospitals and review of the records of the Medical Staff evaluating the practitioner's participation in the delivery of medical care. For those Active Staff members, by virtue of providing outpatient care to patients in Addison County, periodic evaluation shall be performed in accordance with Article IV, Section 4.02(c).

(3) If a physician, at initial application to the Medical Staff, at reappointment, or at any time during an appointment cycle, requests privileges for a procedure or technology for which the Hospital or Department requires additional credentials, the physician will have to meet the criteria that the Hospital has established before being granted privileges to perform that particular procedure or utilize that particular technology. The request will be treated as a request for increased or additional privileges.

(4) Requests for initial and additional or supplemental clinical privileges shall be granted or denied on the basis of documented, appropriate training, experience, and current competence. Minimum qualifications include but are not limited to:

(a) Completion of appropriate training as established by technical and/or professional standards.

(b) Actual experience and demonstration of knowledge of the indications for the procedure, test or therapy and performance thereof.

(c) Letters from supervisors or training programs supporting the claim to training and experience in applicable or requested procedure, test or therapy.

The Minimum Threshold Criteria utilized to make such a determination shall be developed and updated pursuant to Section 6.02 hereof. In addition to the foregoing, the Committee shall consider the setting required for exercise of the proposed privileges and the facilities, equipment, number and type of qualified support personnel, and other resources available in the Hospital and required to support the privileges at issue. The applicant has the burden of producing supporting information to demonstrate his/her qualifications for the privileges requested to the satisfaction of the Department Chief, Credentials Committee, Executive Committee and Board of Directors.

Section 6.02 CRITERIA FOR PRIVILEGES

(1) Many clinical privileges that are available to applicants for appointment and re-appointment to the Medical Staff are Department-specific. From time-to-time, however, there are current or new procedures, studies, technologies, and techniques that, based upon current and evolving professional standards, can safely and competently be performed, read, and/or utilized by more than one specialty or subspecialty. Moreover, new procedures, studies, technologies, and techniques are routinely introduced at the Hospital. In order to ensure that quality of care is enhanced, that the criteria used to evaluate applicants for the privileges at issue are appropriate

and standardized, and that only practitioners who are competent to exercise the privileges at issue are awarded such privileges, the Minimum Threshold Criteria for privileges and requests for expansion of the privileges available to members of a Department must be carefully evaluated.

(2) A Department Chief may request expansion of a Department's delineation of privileges list to include the (a) availability of a procedure, study, technology or technique that has heretofore been within the domain of another Department, or (b) expansion of their own delineation of privileges list to include a procedure, study, technology or technique that is new to the Hospital, by making a request in writing to the Executive Committee which will adjudicate any conflict and make a recommendation to the Board.

Section 6.03 TEMPORARY PRIVILEGES

Section 6.03(1) REQUESTS BY APPLICANT FOR APPOINTMENT - A request for temporary privileges will only be granted to fulfill an important and pressing patient care need. A request for temporary privileges may be processed only upon receipt of:

(a) a written request for temporary privileges, including the reasons why such privileges are necessary;

(b) an application that has been deemed complete as described in Section 3.04

Section 6.03(2) EVALUATION - The following will be evaluated in connection with any request for temporary privileges on a case by case basis, but the existence of any of the following will result in ineligibility for such privileges:

(a) there is a pending or previously successful challenge to the applicant's licensure or certification in any jurisdiction;

(b) the applicant's medical staff membership or privileges have been involuntarily terminated, limited, reduced or denied at another institution; and/or,

(c) there has been either an unusual pattern of or an excessive number of professional liability actions resulting in a final judgment against the applicant.

Section 6.03(3) DURATION OF TEMPORARY PRIVILEGES - The Hospital President or his/her designee, based upon the information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant, and after consultation with the Department Chief concerned and the Medical Staff President, may grant contingent temporary admitting and/or clinical privileges to an applicant for a period of up to ninety (90) days after the receipt of all of the information described in Section 6.03(1) above. In exercising such privileges, the applicant will be monitored by the Chief of the Department in which he has requested privileges.

Section 6.03(4) CARE OF SPECIFIC PATIENTS - Notwithstanding the foregoing, temporary admitting and/or clinical privileges may be granted to an appropriately licensed physician who is not applying for medical staff appointment for consultation or care of a specific patient or patients. Each such request for temporary privileges shall be restricted to the treatment of one specific patient, limited to the dates of that patient's current admission, with subsequent readmission requiring the granting of new privileges, with a limit of no more than five such requests in any 12-month period, after which the practitioner shall be required to apply for appointment to the Medical Staff before being allowed to attend additional patients. Such requests will be granted only to provide clinical expertise that cannot otherwise be provided by members of the Medical Staff. Temporary privileges may be granted by agreement of the Department Chief, Medical Staff President and Hospital President pursuant to this Section 6.03(4) upon receipt and approval of the following: (1) written or verbal request of the patient's attending stating the reasons for the request, (2) curriculum vitae which provides necessary information for querying the National Practitioner Data Bank, (3) current Vermont medical license, (4) Drug Enforcement Administration Registration, (5) evidence of acceptable professional liability insurance coverage, (6) a letter of reference from the Chief of the applicant's Department at his/her primary hospital, (7) evidence that the practitioner is not a Sanctioned Person, and, (8) a satisfactory report from the National Practitioners Data Bank.

Section 6.03(5) LOCUM TENENS - Temporary privileges may be granted by the Hospital President or his/her designee to a practitioner who is serving as a locum tenens for a member of the Staff upon receipt of a written request for specific temporary privileges from the member seeking coverage. Locum tenens practitioners seeking temporary privileges will be credentialed in the same manner as initial applicants to the Medical Staff, except that the requirement for some or all of the references described in Section 3.04 may be waived by the Executive Committee. Locum tenens privileges may be granted for an initial period of six months and may be renewed for one successive period of six months. The locum physician may not provide more than eight weeks of service per calendar year using temporary privileges. Should the locum physician wish to provide more than eight weeks of service per calendar year s/he must become a member of the Medical Staff.

Section 6.03(6) TERMINATION OF TEMPORARY PRIVILEGES – The Hospital President may, at any time, terminate an individual's temporary privileges effective as of the discharge from the Hospital of the individual's patients then under his care in the Hospital. However, where it is determined that the life and health of such patients would be endangered by the continued treatment by the individual, the termination may be imposed by any person entitled by these Bylaws to impose a summary suspension and the same shall be immediately effective. The appropriate Department Chief or in his absence the Medical Staff President shall assign an appointee of the Medical Staff to assume responsibility for the care of such terminated individual's patients until they are discharged from the Hospital.

Section 6.03(7) PROCEDURAL RIGHTS - The denial of a request for or termination or suspension of an individual's temporary privileges for any reason does not entitle a practitioner to the procedural rights contained in Sections 3.13, 3.14 and 3.15 of these Bylaws.
of these Bylaws.

Section 6.04 EMERGENCY AND DISASTER PRIVILEGES.

Section 6.04(1) EMERGENCY PRIVILEGES - In the case of an emergency, any practitioner to the degree permitted by his/her license and regardless of Department or Staff status, shall be permitted and assisted to do everything possible to save the life of a patient using every available facility of the Hospital. For the purpose of this section, an emergency is defined as a condition in which serious permanent harm would result to a patient if immediate treatment was not offered or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. The practitioner exercising emergency privileges must summon assistance deemed necessary and arrange for appropriate follow-up care. Emergency privileges will cease when the emergency no longer exists.

Section 6.04(2) DISASTER PRIVILEGES - A disaster exists when the Hospital has activated its Emergency Preparedness Plan and is otherwise unable to handle its immediate patient needs with its current staff. During a Disaster, the Hospital President or his/her designee , has the discretion to grant disaster privileges to practitioners. If neither the Hospital President nor a designee is available, the Medical Command Physician on duty in the Emergency Department shall have the discretion to grant such privileges. Emergency privileges granted pursuant to this Section 6.04(2) shall terminate upon the Disaster's conclusion. The individual given the discretion to grant emergency staff privileges set forth in Section 6.04(2) above, may grant such privileges only upon the presentation of a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) AND ANY ONE of the following:

(a) a current photo hospital identification card that clearly identifies professional designation; or

(b) a current license or certification to practice their profession; or

(c) primary source verification of the license; or

(d) identification that states that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps, Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organization or group; or

(e) identification that states that the individual has been granted authority by a federal, state or municipal entity to render patient care in emergency circumstances; or

(f) identification by a current Medical Staff Member who possesses personal knowledge of the individual's licensure and ability to act as a licensed independent practitioner during a disaster.

Section 6.04(3) VERIFICATION - Primary source verification of the practitioner's license or certification must begin as soon as the immediate situation is under control and completed within 72 hours of the practitioner's presentation to the Hospital or, in extraordinary circumstances, as soon as possible after it can be accomplished. If the Disaster is prolonged, the immediate situation is under control, and there is a need for the continued services of the practitioner granted disaster privileges pursuant to Section 6.04(2) hereof, the Medical Staff shall begin the process of verifying the credentials of individuals granted disaster privileges. Such verification of disaster privileges will follow the Credentials process for temporary privileges set forth in Section 6.03 of these Bylaws, except that the practitioner will not be limited in terms of their involvement in patients care and such privileges may be granted by the Hospital President, the Administrator on Call, or the Medical Command Physician. A decision respecting the extension of disaster privileges will be made within 72 hours of the practitioner's presentation to the Hospital or, in extraordinary circumstances, as soon as possible after it can be accomplished.

(a) If primary source verification of a practitioner's license could not be accomplished within 72 hours due to extraordinary circumstances, the following documentation must be maintained: (i) a description of the extraordinary circumstances; (ii) evidence of a demonstrated ability to continue to provide adequate care, treatment and services; and, (iii) an attempt to rectify the situation as quickly as possible.

Section 6.04(4) OVERSIGHT AND IDENTIFICATION - The Medical Staff will maintain written Executive Committee mechanisms to:

(a) oversee the professional performance of practitioners with disaster privileges (e.g., through direct observation, mentoring, or clinical record review); and,

(b) to readily identify practitioners who have been granted disaster privileges.

Section 6.05 ALLIED HEALTH PROFESSIONALS

Section 6.05(1) SCOPE OF PRIVILEGES - Allied Health Professionals may render service to Hospital patients under the following conditions: each individual in this category will present his/her qualifications on an application form prescribed by the Hospital, including evidence of graduation from an appropriate educational program, unrestricted licensure if required for the privileges requested, appropriate liability insurance (including proof of adequate minimum coverage for the State of Vermont or as required by the Board), DEA registration if prescriptive authority is being requested, a copy of any agreement required by Vermont law for the AHP to provide services that is signed by a member of the Staff and evidence that such agreement is maintained on file with and has been approved by the individual's licensing agency if required, and certification/re-certification (where applicable) for review by the Credentials Committee, the Executive Committee, and the Board. The Board may grant such individuals privileges as recommended by the Executive Committee. The eligibility of such practitioners shall be determined on the basis that they meet the following criteria:

(a) They participate directly in the management of patients under the general supervision and/or direction of or collaboration with a member of the Medical Staff. Each supervising/collaborating physician of a licensed AHP shall designate at least one physician to provide substitute supervision or direction in his/her absence or when he/she is unable to provide the requisite supervision or direction.

(b) They record reports and progress notes respecting their services in patients' records and write orders to the extent established by the Medical Staff.

(c) They may perform the admission history and physical (H&P) so long as the supervising physician physically sees the patient and co-signs the H&P within one day.

Individual scopes of practice will be evaluated and granted by the specific Department. If the scope of practice falls within the scope of more than one Department, all such Departments must be in agreement as to the scope of practice granted. (Similar to: Family Practitioners requesting OB privileges must be approved by their primary Department, Family Practice, as well as Obstetrics.)

Section 6.05(2) EVALUATION - The Medical Staff Coordinator will investigate and verify the information provided by the AHP. The Credentials Committee shall evaluate the candidate's education, qualifications, proposed duties as delineated by the supervising or directing physician, and current competence to carry out those duties and delineate the privileges recommended to be granted. Recommendations to the Executive Committee shall be transmitted to the Board of Directors for approval. The applicant shall, at the time of application and throughout the period that they are granted privileges, have the burden of producing adequate information to demonstrate current competence and qualification, based upon his/her experience, background, training, ability, performance, and Medical Staff criteria, for the clinical privileges he/she requests.

Section 6.05(3) TERMINATION OF APPOINTMENT - If there are any modifications to any agreement required by law between an AHP and the physician(s) under whose supervision or direction they have been granted privileges, those modifications will be provided to the Medical Staff Coordinator immediately and reviewed by the Credentials Committee at its next regularly scheduled meeting. If such modifications require a modification in the privileges that have been granted to the Allied Health Professional, the Credentials Committee will make recommendations respecting modification of such privileges as it deems appropriate to the Executive Committee, and the Executive Committee will make its recommendations to the Board. If an AHP's supervising or directing physician ceases to be a member of the Staff or no long holds clinical privileges that are required for supervision or direction of the services the AHP is authorized to provide (each a "Terminating Event"), the AHP shall immediately notify the Medical Staff Coordinator of such change. Unless the AHP provides the Medical Staff Coordinator with a copy of a new agreement that, if required by the Professional's certifying agency, has been filed with and approved by the certifying agency, with a physician who is a member of the Staff, the AHP's authorization to provide services in the Hospital will cease immediately upon the Hospital's knowledge of the Terminating Event. Termination of an AHP's privileges does not and will not afford the AHP any

procedural rights hereunder.

ARTICLE VII
Immunity from Liability

Section 7.01 CONDITION OF IMMUNITY - The following shall have force and effect and be express conditions on an individual's membership on the Medical Staff and on an individual's application for appointment or re-appointment to the Medical Staff or for the granting of temporary privileges:

(a) That any act, communication, report, recommendation or disclosure with respect to any individual seeking staff privileges and membership, performed or made in good faith without malice and at the request of an authorized representative of this Hospital or any other health care facility or agency for the purpose of achieving and maintaining quality care in this Hospital or any other health care facility shall be privileged.

(b) That such privilege shall extend to all members of the Medical Staff, the Board, the Hospital President and his/her representatives, and to any third parties, both individuals and organizations, who supply information to any of the foregoing who are authorized to receive, release or act on the same.

(c) That there shall be absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure, even where the information involved could otherwise be deemed not to be privileged.

(d) That such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this Hospital or any other health care institution or agency, and activities related to, but not limited to:

1. Applications for appointment or reappointment for Medical Staff membership and temporary privileges;

2. Periodic reappraisals for appointment or delineation of clinical privileges;

3. Corrective action including suspension or revocation of privileges;

4. Hearings and appellate reviews;

5. Medical care evaluations;

6. Utilization reviews; or

7. Other Hospital Department or committee activities related to quality patient care and professional conduct.

(e) That the acts, communications, reports, recommendations and disclosures referred to in this Article may relate to an individual's professional qualifications, clinical competency, character, mental and emotional stability, physical condition, ethics, and any other matter that might directly or indirectly have an effect on patient care.

ARTICLE VIII
Officers and Committees

Section 8.01 OFFICERS - The officers of the Medical Staff shall be the Medical Staff President (Chief of Staff), the Vice President, the Secretary-Treasurer and the chief of each clinical Department. They shall be elected pursuant to the procedures set forth in Section 9.02. All officers shall be members of the Active Medical Staff. No officer, excluding Department Chiefs, may serve more than two consecutive terms in the same office. The Medical Staff President may not serve as an elected member of the Board.

The Medical Staff President shall call and preside at all meetings, shall be a member ex-officio of all committees, and shall have general supervision over all professional work of the Medical Staff. The Vice President shall, in the absence of the Medical Staff President, assume all of the duties and authority of the Medical Staff President. The Vice President shall also be expected to perform such duties of supervision as may be assigned to him/her by the Medical Staff President. The Secretary-Treasurer shall keep accurate and complete minutes and a register of attendance at all meetings, call meetings on order of the Medical Staff President, attend to all correspondence, and perform such other duties as ordinarily pertain to his/her office. Where there are funds to be accounted for, the Secretary-Treasurer shall also act as Treasurer.

Section 8.02 REMOVAL OF OFFICERS - In the event that an officer fails to comply with the terms of her/his office, and upon the petition of one third of the members of the Medical Staff and upon notice to all members, given at least ten (10) days prior to a regular meeting of the Medical Staff, a vote may be taken to remove any officer of the Medical Staff. If a quorum of the total Active Staff members vote in favor of removing the officer, the officer shall be removed. In the event that any officer of the Medical Staff becomes an inactive staff member or otherwise has his/her membership suspended or revoked, he/she shall immediately resign from office. Where a vacancy in office exists, it shall be filled pursuant to Section 9.02.

Section 8.03 COMMITTEES - Committees of the Medical Staff shall be standing and special. All Medical Staff committees, other than the Executive Committee, shall be appointed by the Medical Staff President, except as stated otherwise in these Bylaws. All committees shall report to the Executive Committee and as deemed necessary, to the Medical Staff as a whole regarding non-confidential information. Minutes shall be kept of all committee meetings. The Chairperson of each committee shall produce a timely record of the minutes and provide a copy to the secretary of the Medical Staff. Committees shall meet at least annually.

Medical Staff Committees

Section 8.04 STANDING COMMITTEES - The standing committees shall consist of the following: Executive Committee, Credentials Committee, Planning Committee, Nominating Committee, and Medical Care Review Committee.

Section 8.04(1) EXECUTIVE COMMITTEE - The Executive Committee shall:

(a) act as a liaison group among the Medical Staff, the Hospital President, and the Board;

(b) be empowered to act for the organized medical staff between meetings of the organized medical staff;

(c) coordinate the activities and general policies of the Departments;

(d) receive reports of all minutes of the special and standing committees of the Medical Staff;

(e) oversee the activities of those committees;

(f) make recommendations on committee reports;

(g) act on those reports if, by a majority vote of those members present, action on a recommendation prior to the next meeting of the Medical Staff as a whole is deemed necessary;

(h) oversee and direct the activities of the Medical Staff;

(i) keep the Medical Staff abreast of the Accreditation Program and keep key members of the staff informed of the accreditation status of the Hospital;

(j) review and make recommendations relating to the granting, restricting or denial of Medical Staff membership and privileges as set forth in these Bylaws;

(k) make recommendations directly to the Board for its approval concerning (1) the structure of the Medical Staff; (2) the Executive Committee mechanisms used to review credentials and to determine individual clinical privileges; (3) the selection of individuals for Medical Staff membership; (4) the designation of each staff member's delineated clinical privileges; (5) the organization of the quality assessment and improvement activities of the Medical Staff as well as the Executive Committee mechanisms to conduct, evaluate, and revise such activities; and (6) the Executive Committee mechanism by which Medical Staff membership may be terminated; and

(l) present at each regular staff meeting a report of any final action that it may have taken since the last meeting.

Composition - The Executive Committee shall consist of the officers of the Medical Staff and the Department Chiefs and the director of the Hospitalist Service. The Medical Staff President shall be its Chair and shall preside at meetings. If a Chief is also an officer of the staff, such Chief will designate someone to represent the service on their behalf. The Executive Committee includes physicians and may include other licensed independent practitioners. The Hospital President shall be an ex-officio member and shall attend all meetings of this committee.

Except when called into executive session for consideration of items pursuant to Sections 3.11, 3.12, 3.13, and for consideration of any other peer review related matter or items which a majority of the committee members present agree requires an executive session, the regular meetings of the Executive Committee are open to members of the Active Medical Staff. A detailed agenda for the regular meetings of the Executive Committee, which includes any items which may require action by the committee with the exception of any confidential matters as set forth in these Bylaws, shall be made no available no later than five working days prior to the regular committee meetings. Actions of the Executive Committee under executive session, as outlined above, may be taken without prior notification. However, all other actions by the Executive Committee may be taken only on issues which appear on the agenda. In addition to its regularly scheduled monthly meetings, this committee may meet if the Medical Staff President or a majority of the Executive Committee so requests or as necessary to address matters which cannot prudently be left until the time of the next scheduled staff meeting. The Medical Staff Coordinator shall maintain a permanent record of its proceedings.

Section 8.04(2) THE CREDENTIALS COMMITTEE - Pursuant to Section 3.04(2), the Credentials Committee shall act as an investigative committee whose duties shall be to review the credentials of all applicants for staff membership and to make recommendations for staff membership category and delineation of privileges as appropriate. Its members shall be appointed by the Medical Staff President. It shall act in accordance with the Credentials Committee Operational Plan. It shall report to the Executive Committee on each applicant and shall consider the recommendations from the appropriate Department Chief(s).

Section 8.04(3) THE MEDICAL CARE REVIEW COMMITTEE - The Medical Care Review Committee shall consist of at least three (3) members of the Medical Staff, appointed by the Medical Staff President, who insofar as possible shall be representative of the clinical Departments of the Staff. The Chairperson shall be elected by the committee and he/she may call it into executive session when necessary. The Hospital President, or his/her representative; and the Medical Record Administrator shall attend each meeting. The organization and operation of the committee and its function shall be in accordance with the written Operational Plan of the Medical Care Review Committee as approved by the Committee, the Medical Staff, and the Board. The committee shall have the responsibility of appraising functions of the Medical Staff, and of utilization review as required for participation in federal and state health programs. This responsibility, as described in the Operational Plan, shall

include: (1) supervising the maintenance of medical records at the required standard of completeness; (2) evaluating the quality of medical care given to patients; (3) reviewing all surgical procedures to determine agreement or disagreement among the pre-op, post-op, and pathological diagnosis, as well as outcome; (4) determining whether the surgical procedures undertaken in the Hospital were acceptable or not; (5) determining proper utilization of the Hospital facilities in terms of necessity of admission, proper time of discharge or transfer, and promptness of carrying out procedures for diagnosis, consultations and treatments; (6) reviewing records of patients who have received transfusions of blood or blood derivatives, and investigating transfusion reactions; (7) reviewing requests for corrective action. In the event of an unresolved concern, the committee shall report to the Executive Committee, in accordance with its Operational Plan.

Section 8.04(5) NOMINATING COMMITTEE - The Nominating Committee shall be appointed by the Medical Staff President and shall consist of three Active Medical Staff Members representing different clinical Departments whose function shall be to nominate annually a slate of officers, excluding chiefs of Departments.

Special Committees

Section 8.05 SPECIAL COMMITTEES - The special committees shall consist of, but are not limited to the following: Bylaws Committee.

Section 8.05(1) BYLAWS COMMITTEE - The Bylaws Committee shall concern itself with review and revision of the Medical Staff bylaws and rules and regulations. It shall be chaired by a member of the Medical Staff who is appointed by the Medical Staff President. Other members of the Committee shall be appointed as deemed necessary by the Medical Staff President~~, the Hospital~~, and/or the Medical Executive Committee. Specifically, it shall address the biennial review and revision of the bylaws as required under Section 10.02. The Bylaws Committee shall make recommended changes for the review and approval of the Executive Committee. In addition the Medical Executive Committee may advise the Bylaws Committee on any bylaws changes proposed by the Medical Staff and approved by majority vote of the Medical Executive Committee. The Chair of the Bylaws Committee shall be responsible for convening the committee.

Section 8.06 PROFESSIONAL AND PEER REVIEW COMMITTEES - CONFIDENTIALITY – The Executive Committee, the Credentials Committee, the Medical Care Review Committee,-are formed to evaluate and/or improve the quality of health care rendered by members and prospective members of the Medical Staff. Information with respect to any physician that is submitted, collected or prepared by any committee member or clinical Department Chief or other individual for the purpose of achieving and maintaining the quality of health care rendered is privileged and shall be kept confidential to the fullest extent permitted by law, and by the procedures set forth herein. Such information shall not be disclosed or disseminated by any committee members other than as specified in these Bylaws and shall not become part of any patient's medical records or of the general Hospital records.

Section 8.07 LIAISON PHYSICIANS - The Medical Staff shall have one or more physicians on the following committees and Departments of the Hospital, to be appointed by the Medical Staff President, to act as liaison physicians, the Quality Council and Pharmacy and Therapeutic Committee. Liaison physicians shall be appointed from time to time as may be required to properly carry out the duties of the Medical Staff. Such physicians shall report to the Executive Committee, and as deemed necessary to the full Medical Staff.

In addition to the above responsibilities, liaison physicians to specific committees shall have, but not be limited to, the following specific responsibilities:

(1) Pharmacy and Therapeutic Committee - The liaison physician shall oversee the pharmacological activity of the Hospital and the Medical Staff, and recommend to the Executive Committee, and as deemed necessary, to the Medical Staff, changes in the Hospital formulary.

Section 8.08 MEDICAL STAFF DEPARTMENT CHIEFS - The Medical Staff Department Chiefs shall be responsible for (1) all clinical activities of the Department; (2) all administrative activities of the Department, unless otherwise provided for by the hospital; (3) supervision of the professional performance of all individuals who have delineated clinical privileges in the Department; (4) recommending to the Medical Staff the criteria for delineated privileges in the Department; and (5) recommending delineated privileges for each member of the Department.

ARTICLE IX
Meetings

Section 9.01 THE ANNUAL MEETING - The annual meeting of the Medical Staff shall be held in March at the Hospital or at such time and place as the Active Medical Staff may determine. At this meeting, the retiring officers, Department Chiefs, and committees shall make annual reports. The officers, excluding Department Chiefs, for the ensuing year shall be elected, and recommendations for reappointments to the Medical Staff shall be made.

Section 9.02 METHOD OF ELECTION - Nominations of officers shall take place at the Executive Committee meeting at least one month preceding the annual meeting. The election shall be by ballot, and a majority shall be necessary for an election. In the event that there are more than two nominations for the same position and no candidate receives a majority on the first ballot, the candidate receiving the least number of votes shall be dropped on the second ballot, and so on until a majority is obtained. The current officers shall hold office until the adjournment of the March meeting, when the newly-elected officers take over. Vacancies shall be filled by election at a meeting of the Medical Staff, and the officer or member so elected shall hold office until the next annual meeting or until her/his successor has been elected.

Section 9.03 REGULAR TRIANNUAL MEETINGS AND ATTENDANCE REQUIREMENTS - The triannual meeting of the Medical Staff shall be held on the second

Wednesday of every fourth month. In addition to attendance requirements at Department meetings established by the Departments, each member of the Active Medical Staff shall be required to attend at least three of the Medical Staff meetings in each two year period of appointment. Reinstatement of staff members whose membership has been revoked because of absence from staff meetings and/or Department meetings shall be made only upon application as for original appointment.

Section 9.04 QUORUM - One-third of the members of the Active Medical Staff and Podiatric Staff shall constitute a quorum.

Section 9.05 SPECIAL MEETINGS - Special meetings of the Medical Staff may be called at any time by the Medical Staff President or on request of any three (3) members of the Active Medical Staff. Notice of regular or special meetings shall be posted and mailed to all members of the staff at least three (3) days before any regular or special meeting. The notices shall state the nature of the business for which the meeting has been called, the time, and the place for the meeting.

ARTICLE X
Miscellaneous

Section 10.01 RULES AND REGULATIONS - The Medical Staff shall adopt such rules and regulations consistent with these Bylaws as may be necessary for the proper conduct of its work. They may be amended by a two-thirds vote of the Active Staff, providing that the proposed amendment has been announced at the previous regular meeting. Such rules and regulations shall become effective when approved by the Board.

Section 10.02 BIENNIAL REVIEW - The Executive Committee, in conjunction with the Bylaws Committee, shall review these Bylaws and any rules and regulations adopted hereunder every other year in order to ascertain their appropriateness and make recommendations for amendments.

Section 10.03 AMENDMENTS - These Bylaws may be amended after notice given at any regular meeting of the Medical Staff. After such notice, voting shall be postponed until the next regular meeting and shall require a two thirds vote of the quorum of the total Active Staff membership. An amendment shall become effective when approved by the Board. Neither the Board nor the Medical Staff may amend these Bylaws unilaterally.

Section 10.04 ADOPTION - These Bylaws shall be adopted by majority vote at any regular meeting of the Active Medical Staff and shall become effective when approved by the Board. They shall, when approved, be equally binding on the Board and the Medical Staff.

Section 10.05 RULES OF ORDER - Robert's Rules of Order, Newly Revised, shall govern the conduct of all meetings of the members of the Medical Staff, and all committees of the Medical Staff, unless inconsistent with these Bylaws, which shall prevail.

Section 10.06 FORM - Wherever from the context it appears appropriate, each term stated in either the singular or the plural shall include the singular and the plural, and the pronouns, stated in either the masculine, the feminine, or the neuter gender shall include the masculine, feminine and neuter.

Section 10.07 NOTICES - Any notice to be given herein shall be in writing and shall be deemed given if delivered, or mailed by certified mail, postage prepaid, addressed to the party at her/his last known address and to Porter Hospital, Inc. if addressed as follows:

Attn: Hospital President
Porter Hospital, Inc.
Middlebury, Vermont 05753

or to such other address as either party may designate in accordance with the provisions of this section.

Section 10.08 COMPUTATION OF TIME - In computing any period of time prescribed or allowed by these Bylaws the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a legal holiday. When the period of time prescribed or allowed is less than seven (7) days, intermediate Saturdays, Sundays, and legal holidays shall be excluded in the computation.

RULES AND REGULATIONS

1. Patients may be admitted and treated only by Medical Staff Members of Porter Hospital, Inc.

2. No patient shall be admitted to the Hospital without a provisional diagnosis by the attending Medical Staff Member ("the Attending"). Such members admitting patients shall be held responsible for giving such information as may be necessary to protect their patients and other patients in the Hospital.

3. On Call physicians must be able to be physically present in the emergency room within forty-five minutes after being called for duty.

4. Standing orders shall be coordinated by conference between the Medical Staff, the Pharmacy Staff and the Nursing Service. These orders shall be followed insofar as proper treatment of the patient will allow, and when specific orders are written by the Attending they shall constitute the orders for treatment. Narcotic orders and controlled Drug Enforcement Agency Class I and II drugs shall be automatically cancelled per hospital policy in the acute care unit of the Hospital. All other drug orders shall be cancelled per hospital policy unless the

physician has stipulated a given number of days.

5. An order shall be considered to be in writing if dictated to a registered nurse, a Hospital pharmacist, a registered physical therapist or a certified respiratory therapist, and signed by the Attending within 24 hours. An order dictated by an alternate Medical Staff Member may be signed by the attending physician. All verbal or telephone orders must be signed within 72 hours.

6. The Attending shall be held responsible for the preparation of a pertinent medical record for each patient, except that dentists are responsible for and perform that part of their patients' history and physical examination that relates to dentistry and podiatrists are responsible for and perform that part of their patients' history and physical examination that relates to podiatry. This record shall include history and physical exam including identification, date, chief complaint, present illness, past medical history, family history, social history, review of systems, consent forms, clinical laboratory reports, x-ray reports, pathological reports, medical or surgical treatment, progress notes, operative report, final diagnosis, summary or discharge note, and autopsy findings.

In all instances a pertinent history and physical examination shall be written or dictated within twenty-four hours after admission. Such examination may be written or dictated within 30 days before admission; however, an interval note is required for all examinations written or dictated more than 24 hours before admission. When the medical history and physical examination are completed within 30 days before admission or registration, the updated examination must be completed and documented prior to surgery or a procedure requiring anesthesia services.

An integrated problem list for each admitted patient shall be updated as necessary, concurrent with each admission.

A complete list of all medications, including dosages, with which the patient is being treated at the time of admission, shall be included with the history.

When a history and physical examination are not recorded before the time an operation is scheduled to be performed in the operating room, the operation shall be cancelled unless the attending surgeon states in writing that the delay will be detrimental to the patient. History and physical examinations of outpatient minor surgery patients in the emergency medicine Department may be focused if medically appropriate.

7. (a) Each medical staff member shall be responsible for the preparation of a complete and legible medical record for each patient. The contents shall be accurate, timely, pertinent and current for each patient, with each entry dated with the time. All medical records shall be confidential, and they shall be the property of the Hospital. They shall not be removed without permission of the Hospital President. Records may be removed from the Porter Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statutes. Access to medical records shall be afforded to members of the Medical Staff in

accordance with the Hospital's privacy and security policies. When a patient is readmitted, all previous medical records shall be available for the use of the Attending.

(b) All patients undergoing major surgery must be evaluated by the surgeon preoperatively and they shall have an appropriate laboratory evaluation finished before surgery is performed.

(c) All operations shall be fully described by the operating surgeon immediately following surgery. The description shall contain a statement of the physician's findings, the technique used, the tissue removed or altered, and the post-operative diagnosis.

(d) All tissues removed at operation shall be sent to the Hospital Pathology Department, except as specified by the Department of Surgery, which shall make such examination of the tissue as may be considered necessary to arrive at a pathological diagnosis.

(e) The time designated for an operation shall be understood to mean that the incision shall be made at the hour designated for the operation.

(f) A preoperative diagnosis shall be recorded on all patients prior to surgery.

(g) Surgery shall be performed only after informed consent or request is obtained from the patient or her/his legal representative, acknowledging the hazards of the procedure and the availability of alternative methods of treatment, except in the case of emergency.

8. Physicians practicing in the Special Care Unit will conform to the Special Care Unit Rules and Regulations of the Combined Medical Staff-Nursing Staff Special Care Unit Committee.

9. The Medical Staff shall endorse the use and principles of the problem oriented medical record system in completing medical records. It shall also require a problem list coordinating prior inpatient and/or outpatient problem lists.

10. It shall be the responsibility of each Medical Staff Member to provide for the coverage of another staff member with appropriate privileges to attend to her/his Hospitalized patients in her/his absence, and to notify the appropriate Hospital Departments.

11. The medical care of a dental patient admitted to the Hospital shall be the responsibility of an active staff member, except that dentists are responsible for the part of their patients' history and physical examination that relates to dentistry.

(a) The Hospital, as a safety net provider and Critical Access Hospital, is eligible to participate in the Federal 340B Drug Discount Program. Under the 340B Program, the Hospital is able to access discounts for high cost drugs administered to outpatients. The requirements for a patient to be eligible to receive drugs through the 340B Program include the

patient having a relationship with the Hospital by which the Hospital has assumed responsibility for the patient's care (demonstrated by the existence of medical records) as well as the ordering or prescribing provider must either be employed by, contracted with, or under a similar relationship with the hospital. Members of the Medical Staff in good standing with current privileges and AHPs with prescribing privileges meet the definition of a 340B eligible provider. All such providers are eligible to order 340B drugs to be administered to patients either in outpatient status (e.g., observation) or in an outpatient department of the Hospital when all other criteria of 340B eligibility of the patient and prescription are met.

(b) All physician members of the Medical Staff shall comply with Vermont Continuing Medical Education (CME) laws and regulations, as amended from time to time

(c) All licensees are responsible for notifying the appropriate state licensing Board within 10 days of any change of name or address.

12. Podiatric Patients Rules

(a) Podiatric privileges include performing podiatric surgical procedures and consultative inpatient services. Podiatrists do not have hospital admitting privileges, but they may provide podiatric care to hospitalized patients who are formally under the care of a Medical Staff Member with admitting privileges. Surgical procedures requiring either local anesthesia or no anesthesia may be performed by podiatrists in the Emergency Department, Operating Room, or at the patient's bedside. Surgical procedures requiring local anesthesia with sedation, regional anesthesia, or general anesthesia may be performed in the operating room, with all forms of anesthesia (other than local anesthesia) being administered by an anesthesiologist or a supervised CRNA.

(b) Prior to elective podiatric surgery, patients must be evaluated by a physician for a pre-operative medical evaluation. On the day of surgery, podiatrists shall have the privilege to assess the patient for any interval change in their medical condition. If there is none, then the podiatrist may sign the interval medical update. For surgical cases requiring any form of anesthesia other than straight local anesthesia, the patient's interval medical condition will also be assessed by a member of the anesthesia staff and co-signed by the anesthesiologist. If there is a change in the patient's medical condition, then the patient will be referred to a physician for further evaluation. In the outpatient care settings (the ambulatory surgical unit and emergency room), podiatrists' orders do not require co-signature by a physician. On the inpatient unit, all podiatric orders require co-signature by the admitting physician.

(c) If, during the course of an outpatient podiatric surgical procedure, there is an unanticipated medical necessity to extend the patient's care beyond the outpatient ambulatory surgical setting, then podiatric privileges shall include the right to transfer the patient to a member of the Medical Staff with admitting privileges. If the patient does not have an established relationship with one of the members of the Medical Staff with admitting privileges, then the physician on call for unassigned patients would be responsible to review the situation

and either admit the patient to their service or facilitate an appropriate disposition. The delineation of responsibilities for the Podiatrist and the Physician are detailed below.

(i) Podiatrist's responsibilities.

The podiatrist is responsible for performing that part of their patient's history and physical examination that relates to podiatry including: (1) a detailed podiatric history justifying Hospital admission; (2) a detailed description of the examination of the feet and preoperative diagnosis; (3) a complete operative report, describing the findings and technique used; (4) pertinent progress notes; (5) clinical summary or statement; and (6) discharge order.

(ii) Physician's responsibilities. The attending physician shall be responsible for: (1) medical history pertinent to the patient's general health; (2) a physical examination to determine the patient's condition prior to anesthesia and surgery; (3) supervision of the patient's general health status while hospitalized; and (4) verbal or written co-signature of all orders given by the podiatrist.

13. It will be the responsibility of the attending physician to state by written order if "No code" is desired for a particular patient.

14. A patient shall be discharged only on written order of the Attending.

15. A consultation report shall be an opinion of the consulting person, written legibly in the patient's chart and identified either by a particular form and/or by entitling it as such. Whatever format the consultant chooses to use, her/his report shall contain evidence of an examination of the patient, whatever medical records that are available and any other pertinent data.

16. Autopsies.

(a) Every member of the Medical Staff shall be concerned in securing autopsies whenever appropriate. No autopsy shall be performed without legal consent. All autopsies shall be performed by the pathologist or her/his representative, or by a physician to whom she/he may delegate the duty, except as may be otherwise required by law.

(b) A request for autopsy shall be made by the physician in attendance at the time of a patient's death and recorded in the Hospital record if:

1. Death occurs within 24 hours of admission to the Hospital.

2. Death occurs within the Hospital prior to admission.

3. The cause of death and/or the presence of other factors related to the patient's health prior to death remains in question.

17. All non-privileged committee and Department meeting reports and minutes shall be available at the subsequent Executive Committee meeting and Medical Staff meeting, copies of which shall be maintained by the Medical Staff Coordinator.

18. Minutes of the staff meetings shall document a thorough review of the clinical work.

19. Anesthesia Service.

(a) The Anesthesia Service may consist of anesthesiologists and certified registered nurse anesthetists. The policies of the Medical Staff relative to anesthesia care shall be reviewed annually by the Department of Surgery and recorded in the minutes, filed in the Anesthesia Service records, and a copy sent to the Administration. The Anesthesia Service shall be directed by the Director of Anesthesia Services who shall be responsible for (1) quality of anesthesia care rendered by anesthetists; (2) availability of equipment necessary for administering anesthesia and for related resuscitative efforts; (3) development and modification as necessary for regulations concerning anesthetic safety; (4) evaluation of all anesthesia care; (5) recommending to the administration the kinds and numbers of personnel and equipment necessary to satisfy the needs of the Hospital; (6) review of the practices of the Anesthesia Service to ensure that they are consistent with the policies of the Medical Staff.

(b) Certified registered nurse anesthetists shall be credentialed as required of members of the Medical Staff, are biennially reviewed and, as appropriate, reappointed as required of members of the Medical Staff, and shall be members of the Allied Health Professional Staff.

20. The treatment of patients for psychiatric illness by members of the Allied Health Professional Staff shall be the responsibility of a psychiatrist who is a member of the Active Medical Staff, who shall be responsible for reviewing and countersigning all records and orders by said Allied Health Professional Staff members, and act in accordance with Section 4.08 of the Medical Staff Bylaws.

21. The Medical Staff shall be responsible for the treatment of patients at Porter Hospital who do not identify an Active Staff Member as their doctor (unassigned patients). The coverage, by each clinical Department, of such patients shall be determined by each clinical Department, and shall be documented in a schedule of assignment which shall be distributed to all Departments of the Hospital and posted prior to start of each day of coverage. It is the responsibility of the physicians specified on the schedule of assignment to provide care, or to arrange adequate coverage for the provision of care, within the scope of their respective clinical

Departments. The day of coverage shall commence at 0700 hours on the stated date and conclude at 0700 hours on the subsequent date.

22. **Telemedicine Policy**

Any telemedicine services provided by practitioners from other health care facilities ("Distant Sites") for the clinical care of Porter Hospital patients ("telemedicine") shall be consultative in nature, unless otherwise approved by the Medical Staff Executive Committee. The services which may be offered through telemedicine must be pre-approved by the Medical Staff Executive Committee, and recommended to the Board for final approval.

The Hospital Medical Staff Member caring for any patient, who is also seen by a Distant Site provider through telemedicine, shall be the attending physician of record and responsible for the care and medical decisions for that patient.

Distant Site providers who provide care via telemedicine are subject to the credentialing and privileging process of Porter Hospital or may be privileged at Porter Hospital using credentialing information from the Distant Site, if a JCAHO-accredited organization.

23. **Telemedicine Confidentiality**

Patient confidentiality shall be maintained wherever medical history and care of a patient are discussed during telemedicine consultations.

The Hospital Medical Staff Member and the District Site provider shall assure that the consultative conference is attended only by individuals who have a bonafide interest in the case (patient, family, providers). Individuals without such interest must leave the room at both sites, absent patient consent to the contrary.

All medical data presented during the consultation must remain confidential and shall be managed consistent with Hospital policies for health information and medical records.

24. It shall be the responsibility of the Medical Staff President to bring any infractions of these Bylaws or Rules and Regulations to the attention of the Hospital President and the Executive Committee for disciplinary action, which may include suspension or revocation of staff privileges and membership. The Secretary of the Medical Staff shall be responsible for maintaining at least three currently correct master copies of these Bylaws, Rules and Regulations, with all amendments, deletions, and additions annotated as to date and approval by the Medical Staff and the Board. One of these copies shall be kept with the staff minutes, another with the Hospital President and the third by the Secretary of the Board.

25. These rules and regulations shall become effective when adopted by the Active Medical Staff at a regular meeting, and approved by the Board.

MEDICAL BYLAWS, RULES, & REGULATIONS

Approved by the Medical Staff on June 16, 2016:

SIGNED ON: August 3, 2016

Kristofer Anderson, MD
President, Medical Staff
Porter Hospital, Inc.

Approved by the Board of Directors on August 3, 2016:

SIGNED ON: August 3, 2016

Maureen McLaughlin, Chairperson
Board of Directors
Porter Hospital, Inc.