SOUTH LAKE HOSPITAL
Clermont, Florida

MEDICAL STAFF BYLAWS

May 2011

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BYLAWS OF THE MEDICAL STAFF
SOUTH LAKE HOSPITAL

PREAMBLE

WHEREAS, South Lake Hospital, Inc. is a non-profit organization, organized under the laws of the State of Florida, with the purpose of providing hospital facilities, support personnel and services for quality patient care and education; and

WHEREAS, it is recognized that the Medical Staff is to strive for quality patient care in the hospital, that the Medical Staff must work with and is subject to the ultimate authority of the Board of Directors, and that the cooperative efforts of the Medical Staff, Management, and the Board are necessary to fulfill the objective of providing quality patient care to its patients;

THEREFORE, the physicians, podiatrists and dentists in this Hospital hereby organize themselves in conformity with the Bylaws, Rules and Regulations, hereinafter stated.

Whenever the term “Board” or “Board of Directors” appears, it shall be interpreted to refer to the governing body of South Lake Hospital, which has the overall authority and responsibility for the affairs of the hospital and the activities of the Medical Staff.

Whenever the term “Executive Director/CEO” appears, it shall be interpreted to mean the Executive Director/CEO or his or her designee, who has been appointed by the Board to act on its behalf in the overall administrative management of the hospital.

Whenever the term “Hospital” appears, it shall be interpreted to mean South Lake Hospital.

ARTICLE ONE

I. MEDICAL STAFF ORGANIZATION AND OPERATIONAL PURPOSE

A. PURPOSE

The purposes of the Medical Staff organization of South Lake Hospital, duly appointed and acting in accordance with these bylaws and subject to the governing authority of the Board, shall be:

1. To monitor and evaluate the quality of medical care in the hospital and to make recommendations thereon to the Board so that all patients admitted to or treated at the hospital shall receive optimum quality care in a cost effective manner.

2. To provide a forum and establish procedures wherein the Medical Staff may review, evaluate and discuss matters of a medical and/or administrative nature with the administration, Board, and other associations, agencies, and organizations.

3. To initiate and maintain self-governance of the Medical Staff.

4. To make recommendations to the Board concerning the appointment or reappointment of an applicant to the Medical Staff of the hospital; to recommend to the Board the clinical privileges such applicant shall have in the hospital and to review and evaluate such clinical privileges on a continuing basis once given; and to recommend to the Board any appropriate action that may be necessary in connection with any member of the Medical Staff, to the end that all persons with clinical privileges shall perform according to current clinical competence.

5. To establish specific rules and regulations to govern actions and professional responsibilities of members of the Medical Staff.

6. To provide an appropriate educational setting that will maintain scientific standards and lead to continuous advancement in professional knowledge and skill.

7. To organize itself to accomplish these purposes by placing responsibility for operational concerns with the hospital while assuring uniformity of direction and purpose and maintaining a single standard of performance through the Medical Staff Executive Committee with representation from each department.

8. To comply with the standards of the Joint Commission in order to maintain accreditation.

ARTICLE TWO

II. MEDICAL STAFF MEMBERSHIP

A. NATURE OF STAFF MEMBERSHIP

1. Membership on the Medical Staff of South Lake Hospital is a privilege, which shall be extended only to physicians, podiatrists and dentists, who continuously meet the qualifications, standards and requirements set forth in these Bylaws. All persons practicing medicine and podiatry in South Lake Hospital must first have been appointed to the Medical Staff. Appointment to and membership on the staff shall confer on the staff member only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws.

2. Ex-officio membership (non-voting) shall be extended to a physician employed by the hospital, who does not exercise clinical privileges but who serves as the medical director of a department within the hospital.

B. QUALIFICATIONS FOR APPOINTMENT

1. The following criteria are designed to assure the Medical Staff and Governing Body that patients will receive quality care.

2. Only such physicians, podiatrists and dentists shall be qualified for membership in the Medical Staff:

   a. Who are currently licensed to practice in the State of Florida;

   b. In the case of physicians who apply on or after June 1999,

      (1) Who are Board Certified in the specialty or subspecialty in which privileges are requested by a Board recognized by the American Board of American Specialties or the American Osteopathic Association; or

      (2) Who are eligible to be admitted to the certification process of a Board recognized by the American Board of Medical Specialties or the American Osteopathic Association in the specialty or subspecialty in which privileges are requested and who can achieve Board Certification within five (5) years after completion of the applicant's residency or last post-graduate training.

   c. In the case of podiatrists:

      (1) Who are Board Certified by the American Board of Podiatric Surgery; or

      (2) Who are eligible to be admitted to the certification process of the American Board of Podiatric Surgery and who can achieve Board Certification within five (5) years after completion of the applicant's residency or last post-graduate training.

   d. Who can document a current Drug Enforcement Administration (DEA) number for use in this region as defined by the DEA, unless not required for the practice of the applicant's specialty;

   e. Who can document their background, experience, training, and demonstrated competence,

their adherence to the ethics of their profession, their good reputation and character, and their ability to work with others sufficiently to convince the hospital that all patients treated by them will receive a high quality of medical care;

f. Who can document their ability to perform the specific privileges requested;

g. Who can provide documentation of current health status regarding their ability to fulfill Medical Staff responsibilities;

h. Who can provide proof of current professional liability insurance in the amounts to be determined from time to time by the Board;

i. Who can provide documentation of each year of continuing medical education with any gaps explained;

j. Who can provide the names of at least three (3) peers, at least one (1) of whom is in the same specialty, who can provide adequate references pertaining to their professional competence, ethical character and ability to perform the privileges requested;

k. Who pay dues and assessments as determined by the Staff and approved by the Board. Such monies are to go into a Medical Staff fund and shall be used at the discretion of the Medical Staff Executive Committee with fifty percent (50%) vote.

3. In making such determination for appointment, consideration may be given to patients' needs, the available hospital facilities and resources, and utilization standards in effect at the hospital.

4. No physician, podiatrist or dentist shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that he or she is duly licensed to practice medicine or podiatry in Florida or any other state, or that he or she is a member of any professional organization, or that he or she had in the past, or currently has, Medical Staff membership or privileges at another hospital.

5. Neither shall any physician, podiatrist or dentist be denied membership on the basis of sex, race, creed, color or national origin.

6. Acceptance of membership on the Medical Staff shall constitute the agreement of the physician, podiatrist or dentist that he or she will:

a. Abide by the Principles of Medical Ethics of the American Medical Association, or the Code of Ethics of the American Osteopathic Association, or the Code of Ethics of their respective associations, whichever is applicable, including but not limited to, providing for continuous care of his or her patients and providing consultations when necessary; and

b. Abide by all bylaws, policies and directives of the hospital, and all Bylaws, Rules and Regulations and Policies and Procedures of the Medical Staff; and

c. Agree to be bound by and comply with the organization's Corporate Compliance Program and Code of Conduct as recognized by business and practice patterns that comply with federal, state, and local laws, statutes, regulations and rules; and

d. Promptly notify the Executive Director/CEO and Medical Staff President of the:

(1) Revocation or suspension of the staff member's professional license, or the imposition of terms of probation or limitation of practice by any state; or

(2) Termination or suspension of the staff member's narcotic license; or

(3) Loss, suspension, or probation of staff membership or privileges or any other professional competence or disciplinary action taken or pending at any hospital, other health care institution, or any professional society for any act which constitutes a violation of the provisions of the Florida Statutes or the Florida Administrative Code which regulate the staff member's practice; or

(4) Voluntary relinquishment of any licensures or registration (state or district, Drug Enforcement Administration) or voluntary limitation, reduction, or loss of clinical privileges at any other hospital or health care facility; or

(5) Commencement of a formal investigation, or the filing of charges by the Department of Health & Human Services or any law enforcement agency or health regulatory agency of the United States or the State of Florida; or

(6) Filing of a suit against the staff member alleging professional liability, or the settlement of any medical malpractice claim or litigation by the staff member or by anyone in the staff member's behalf; or

(7) Conviction of or pleading nolo contendere to any crime, including but not limited to a crime relating to health care; or

(8) Exclusion from or ineligibility for participation in Federal or State health care programs.

7. Staff members who have contractual or employment relationships with South Lake Hospital will be governed by the provisions of their contracts or terms of employment as well as by the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures and the hospital's bylaws. In the event of a conflict between the Medical Staff Bylaws, Rules and Regulations, or Policies and Procedures, and the contractual or employment terms, the contractual or employment terms shall be controlling, provided that they are not in conflict with the Code of Ethics of the American Dental Association, in case of a dentist, with the Principles of Medical Ethics of the American Medical Association in the case of a physician or with the Code of Ethics of their respective associations, whichever is applicable, and provided that the qualifications for appointment, quality standards and quality review systems as set out in these Bylaws may not be altered by contractual or employment terms.

C. CONDITIONS OF APPOINTMENT

1. Initial appointments and reappointments to the Medical Staff shall be made by the Board.

2. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been approved by the Board and shall require that each appointee shall comply with the hospital and Medical Staff Bylaws, Rules and Regulations and Policies and Procedures and assume such reasonable duties and responsibilities as required by the hospital or Medical Staff including but not limited to:

   a. Providing care to service patients;

   b. Providing emergency service care and consultation;

   c. Participate in peer review activities.

D. DURATION OF APPOINTMENT

1. Appointment will be for no more than twenty-four (24) calendar months.

2. Appointments, Provisional

   a. All initial appointments to the Medical Staff shall be provisional. At the end of this period (usually one [1] year), the Medical Staff Executive Committee and the Board, upon the written recommendation of the Credentials Committee, may elevate the provisional member to non-provisional status, or may continue the provisional status of the practitioner's appointment for a maximum of one (1) additional year, or may terminate the provisional appointment for appropriate reasons.

   b. During this period, the provisional member shall meet the Medical Staff meeting requirements for meeting attendance, without vote, and be subject to such other restrictions as set forth in these Bylaws.

   c. A provisional member whose appointment is terminated at the end of two (2) years by a negative vote shall have the right to a fair hearing, in accordance with procedures within these Bylaws.

3. Monitoring Performance of New Appointees

   a. The Quality Review Committee shall implement a monitoring protocol for observation and review of the performance of provisional status Staff members. This information shall be provided to Credentials Committee for further action.

   b. The Credentials Committee shall report in writing to the Medical Staff Executive Committee and the Executive Director/CEO upon the termination of the monitoring protocol respecting each new Staff member.

ARTICLE THREE

III. CATEGORIES OF THE STAFF

A. CATEGORIES

The Staff shall include active, courtesy, active affiliate, and honorary categories.

B. ACTIVE STAFF

1. Active staff members shall be those physicians, podiatrists and dentists:

    a. Who meet the qualifications and conditions for appointment as set forth in these Bylaws; and

    b. Who have a minimum of twelve (12) patient contacts at South Lake Hospital annually (including inpatient and outpatient admissions and consultations); and

    c. Who maintain an office and residence close enough to the hospital to provide timely and continuous care for patients; and

    d. Who retain responsibility within the area of professional competence for the care and supervision of each patient in the Hospital for whom services are provided, or arrange a suitable alternative to provide these services; and

    e. Who agree to assume all functions and responsibilities of membership on the Active Staff, including, when required, the care of service patients, the response to emergency service care and consultation when requested by other members of the Medical Staff, service on Emergency Department call rotation, participation in peer review processes and in the review and evaluation of patient care and other quality maintenance activities required of the staff.

        Note: After fifteen (15) years of service, a member may request an exemption from call and may be granted such exemption by the Medical Staff Executive Committee based upon an adequate number of active staff physicians to provide coverage within a specific specialty. After twenty (20) years of service, a member will be exempt from required call assignments.

    f. Who satisfy the requirements for attendance at meetings of the Staff and committees of which he or she is a member;

2. Active staff members shall be entitled to vote, to hold office, to serve on Medical Staff committees, and to serve as chairperson of such committees, with the following limitations:

    a. No member of the Active Staff may vote at general Staff meetings while a provisional member of the Active Staff (usually for one [1] year), or

    b. Hold Staff office or serve as a committee chairperson while a provisional member of the Staff (usually for one [1] year).

3. Physicians providing contractual services and practicing within the hospital fifty-two (52) days per year (i.e. anesthesia, emergency medicine, radiology and pathology) are eligible for

Active Contractual Staff membership and are not required to meet the patient contact requirements.

C. COURTESY STAFF

1. Courtesy staff members shall be those physicians, podiatrists and dentists:

   a. Who meet the qualifications and conditions for appointment as set forth in these Bylaws; and

   b. Who hold active staff membership at another hospital in the State of Florida where he or she actively participates in peer review processes and in the review and evaluation of patient care and other quality maintenance activities; and

   c. Who have a minimum of two (2) patient contacts at South Lake Hospital annually, including inpatient and outpatient admissions and consultations, unless waived by the Medical Staff Executive Committee for an identified specialty need; and

   d. Who maintain an office and residence close enough to the hospital to provide timely and continuous care for patients; and

   e. Who retain responsibility within the area of professional competence for the care and supervision of each patient in the Hospital for whom services are provided, or arrange a suitable alternative to provide these services; and

   f. Who agree to assume all functions and responsibilities of membership on the Courtesy Staff including, when required, the care of service patients, the response to emergency service care and consultation when requested by other members of the Medical Staff, service on Emergency Department call rotation if there is an inadequate number of active staff physicians to provide coverage within a specific specialty as determined by the Medical Staff Executive Committee, participation in peer review processes and in the review and evaluation of patient care and other quality maintenance activities required of the staff.

2. Courtesy staff members shall <u>not</u> be entitled to vote, to hold office, to serve on Medical Staff committees or to serve as chairperson of such committees.

3. A member of the Courtesy Staff who has twelve (12) or more patient contacts within a one (1) year period will be transferred to the Active Staff.

4. Physicians providing contractual services (i.e. anesthesia, emergency medicine, radiology and pathology) are eligible for Courtesy Contractual Staff membership and are not required to meet patient contact requirements or to hold active privileges at another hospital.

5. Physicians providing contractual services, who act as medical director to the services of pathology, radiology, and emergency department, shall be required to serve on the respective department committees, to attend meetings of the Medical Staff and, if so appointed, may vote and act as chairperson.

D. ACTIVE AFFILIATE STAFF

1. Active Affiliate staff members shall be those physicians:

a. Who meet the qualifications and conditions for appointment as set forth in these Bylaws; and

b. Who practice medicine full-time within the community in a primary care specialty and who utilize hospitalists for their patients who require hospitalization; and

c. Who utilize South Lake Hospital as their primary hospital affiliation, including use of the hospitalist program for their patients who require hospitalization and use of South Lake Hospital for ancillary services.

2. Active Affiliate staff members may not admit inpatients, may not serve as the attending physician for inpatients, and may not write orders or direct the care of inpatients.

3. Active Affiliate staff members may refer patients to the hospitalist program and may participate in the care of the patients they have referred by:

a. Performing outpatient preadmission histories and physicals;

b. Visiting their patients in the hospital;

c. Having access to the inpatient medical record of their patients;

d. Entering progress notes in the inpatient medical record of their patients;

e. Consulting with attending physicians;

f. Obtaining the results of tests and therapy;

g. Ordering outpatient diagnostic tests and services.

4. Active Affiliate staff members will not be eligible for delineated clinical privileges other than "refer and follow" privileges as outlined above and in any applicable clinical privilege description. Should an Active Affiliate staff member wish to apply for additional clinical privileges, he or she must also apply for a change in staff category to Active or Courtesy and meet all applicable requirements.

5. Active Affiliate staff members shall not be entitled to vote, to hold office, to serve on Medical Staff committees, or to serve as chairperson of such committees.

E. HONORARY STAFF

1. The Honorary Staff shall consist of physicians, podiatrists and dentists recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous longstanding service to the Hospital. They shall be recommended by the Medical Staff Executive Committee, subject to the approval of the Board.

2. Members of the honorary staff shall have no assigned duties or responsibilities and are not eligible to vote or hold office. Honorary staff members shall not have clinical privileges at South Lake Hospital.

F. ALLIED HEALTH PROFESSIONALS

1. Allied Health Professionals may be granted privileges at South Lake Hospital as set forth from time to time in the Rules and Regulations of the Medical Staff.

2. Only Allied Health Professionals holding a license, certificate or other legal credentials as may be required by state law who document their experience, background training, demonstrated ability, physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency will be considered. Allied Health Professionals are licensed by the Department of Health and provide a service to patients at South Lake Hospital that is deemed necessary by the Medical Staff Executive Committee. In selected cases, health care providers not licensed by the Department of Health may be considered for privileges based on their credentials and experience. Such licensed and non-licensed individuals who are not Medical Staff members shall be categorized as Allied Health Professionals. Clinical privileges are defined by lists of procedures and treatments to assure that the individual provides services within the scope of privileges granted. Allied Health Professionals in the Hospital shall be categorized as either independent or dependent professionals.

   a. Dependent Allied Health Practitioners

      (1) Dependent allied health professionals shall include those permitted by Law and authorized by the hospital to provide patient care services under the direction of a physician.

      (2) Dependent Allied Health Professional must obtain a physician who is a member of the Medical Staff to act as a supervising (sponsor) physician. When the physician sponsor is removed from the Medical Staff for any reason, including leave of absence or suspension, the Allied Health Professional is automatically removed and his/her clinical privileges are revoked without prejudice, unless the Allied Health Professional obtains another sponsor within thirty (30) days. If the physician sponsor is reinstated to the Medical Staff, the Allied Health Professional and his/her clinical privileges shall be reinstated automatically as well.

      (3) Dependent Allied Health professional applications shall be processed through the Medical Staff Office and be privileged using the same procedures as members of the Medical Staff. A credentials file for each dependent Allied Health Professional containing the individuals training licensure, health status, peer and physician references and malpractice insurance will be maintained by the Medical Staff Office. These individuals can either be privileged or have job descriptions.

   b. Independent Allied Health Practitioners

      (1) Independent Allied Health Practitioners shall include those individuals, as may be determined by the Medical Staff if the need arises, who are permitted by law and authorized by the hospital to provide patient care services independently in the hospital. They must have delineated clinical privileges.

      (2) The initial credentialing requirements for a licensed independent practitioner should

include evidence of education and training, licensure (registration, certification), health status, current competence, ability to perform the privileges requested, peer recommendations, history of professional liability, and query from the national Practitioner Data Bank.

(3) Independent practitioners are appointed, reappointed/reassessed and privileged using the same procedures as members of the Medical Staff. The Medical Staff Executive Committee on the recommendation of the Credentials Committee may recommend to the Board the granting of clinical privileges, and this will be processed according to procedures outlined in the Rules and Regulations.

(4) A credentials file for each independent Allied Health Professional in which the individual's training, licensure, peer and physician references, and malpractice insurance will be maintained by the Medical Staff Office. The Medical Staff Executive Committee may recommend to the Board the granting of clinical privileges to Allied Health Professionals, and this will be processed according to procedures outlined in the Rules and Regulations.

ARTICLE FOUR

IV. PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

A. GENERAL PROCEDURE

1. The Staff, with the assistance of the Executive Director/CEO, the Credentials Committee, and the Medical Staff Office, shall investigate and consider each application for appointment or reappointment to the Staff and each request for modification of Staff membership status and shall adopt and transmit recommendations thereof to the Board.

2. In decisions with respect to appointments, reappointments, modification of appointments and clinical privileges, the Board shall apply the criteria stated in these Bylaws and in addition, shall consider the adequacy of the hospital's facilities and supportive services needed by the applicant for rendering care to patients and the need for additional practitioners with the skill and qualifications of the applicant.

B. APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

1. Information

   a. Applications for appointment to the Medical Staff shall be typewritten or legibly printed, and shall be submitted on the forms prescribed by the Board after consultation with the Credentials Committee.

   b. The application shall require detailed information concerning the applicant's professional qualifications including the following:

      (1) The names of at least three (3) peers, at least one (1) of whom is in the same specialty, who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to their professional competence, ethical character and ability to perform the privileges requested;

      (2) Information as to whether the applicant's Medical Staff appointment and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, or not renewed at any other hospital or health care facility;

      (3) Information as to whether the applicant's membership in local, state, or national medical societies, or license to practice any profession in any state, or narcotic license have ever been suspended, terminated, or voluntarily relinquished, and whether there is any currently pending challenge to such membership or licensure;

      (4) Information regarding the applicant's malpractice experience;

      (5) A consent to the release of information from the applicant's present and past malpractice insurance carriers;

      (6) Recommendation by the Executive Director/CEO, Chief of Staff, or Chief of Service from each current and past hospital affiliation;

(7) Plan for coverage of practice in physician's, podiatrist's or dentist's absence;

(8) A request for specific clinical privileges desired by the applicant and documentation of compliance with the requirements for such clinical privileges as set forth in the applicable Clinical Privilege Description;

(9) A statement that the applicant has been furnished a copy of the Bylaws, Rules and Regulations of the Staff, and that the applicant agrees to be bound by the terms thereof; and

(10) Such other information as the Board may require.

2. Undertakings

Every application for staff appointment shall be signed by the applicant and shall contain:

a. The applicant's specific acknowledgement of the obligation upon appointment to the Medical Staff to provide or make provision for continuous care and supervision to all patients within the hospital for whom he or she has responsibility;

b. The applicant's agreement to abide by all such bylaws, policies, and directives of the hospital, not including policies and directives pertaining to his or her patient care, including all such Bylaws, Rules and Regulations, and Policies and Procedures of the Medical Staff as shall be in force during the time the applicant is appointed to the Medical Staff of the hospital;

c. The applicant's agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him or her by the Medical Staff;

d. A statement that the applicant has received and read a copy of such Bylaws of the hospital and Bylaws, Rules and Regulations, and Policies and Procedures of the Medical Staff as are in force at the time of his or her application and that the applicant has agreed to be bound by the terms thereof in all matters relating to consideration of his or her application without regard to whether or not the applicant is granted appointment to the Medical Staff and/or clinical privileges; and,

e. A statement of the applicant's willingness to appear for personal interviews in regard to his or her application.

3. Burden of Providing Information

a. The applicant shall have the burden of producing adequate information for a proper evaluation of his or her competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications.

b. The applicant shall have the burden of providing evidence that all the statements made and information given on the application are factual and true and to assure that responses are received during the verification process.

4. Statement of Release and Immunity from Liability

a. The following are express conditions applicable to any physician, podiatrist or dentist during his or her appointment or reappointment to the Medical Staff.

b. These statements shall be included on the application form, and by applying for appointment to the Medical Staff and for clinical privileges the applicant expressly accepts these conditions during the processing and consideration of his or her application, regardless of whether or not the applicant is granted appointment to the Medical Staff and clinical privileges as well as for the duration of his or her appointment:

(1) To the fullest extent permitted by law, the applicant or appointee extends absolute immunity to the hospital and its authorized representatives (specifically including but not limited to members of its Medical Staff), and releases the hospital and its authorized representatives from any and all liability arising from any acts, communications, reports, recommendations, or disclosures involving the applicant or appointee, performed, taken, made, or received by this hospital and/or its authorized representatives in good faith during the course of the business of the hospital, to or from any third party, concerning activities relating to but not limited to the following:

(a) Application for appointment or clinical privileges, including temporary privileges;

(b) Periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;

(c) Peer review;

(d) Proceedings for disciplinary or corrective action, including but not limited to, suspension of clinical privileges or revocation of staff membership;

(e) Summary suspension;

(f) Hearings and appellate reviews;

(g) Medical care evaluations;

(h) Utilization and quality reviews;

(i) Exclusion from federal or state healthcare programs or conviction of healthcare related crimes;

(j) Other hospital, departmental, service, or committee activities relating to the quality of patient care or the professional conduct of a physician, podiatrist or dentist; and concerning matters of inquiries relating to a physician's, podiatrist's or dentist's professional qualifications, credentials, clinical competence, character, ability to perform privileges requested or granted, ethics, or any other matter that might directly or indirectly have an effect on the individual's competence, or on patient care, or on the orderly operation of any other hospital or health care facility, including otherwise privileged or confidential information.

(2) Any act, communication, report, recommendation or disclosure performed or made in good faith with respect to any such physician, podiatrist or dentist and at the request of an authorized representative of this hospital or any other hospital or health care facility, for the purposes set forth in A above, shall be privileged to the fullest extent permitted by law. Such privilege shall extend to members of the hospital and its authorized representatives, and to any third parties who supply information as set forth in this section.

(3) The hospital and its authorized representatives are specifically authorized to consult

with the management and members of the Medical Staffs of other hospitals, health care facilities or institutions with which the applicant or appointee has been associated and with others who may have information bearing on his or her competence, character and ethical qualifications.

(4) The hospital and its authorized representatives are specifically authorized to inspect all records and documents that may be material to an evaluation of either the physician's, podiatrist's or dentist's professional qualifications or competence to perform the privileges the physician, podiatrist or dentist requests or currently possesses, as well as the physician's, podiatrist's or dentist's moral and ethical qualifications or stability as they may directly or indirectly affect the individual's competence, patient care, or the good operation of the hospital or any other health care facility.

(5) The applicant or appointee specifically releases from liability all representatives of the hospital, including the Medical Staff, for statements made or acts performed in good faith in evaluating the physician, podiatrist or dentist for any of the purposes or reasons set forth in this section.

(6) As used in this section, the term "hospital" means South Lake Hospital, the members of its Board and their appointed representatives, the Executive Director/CEO, the Medical Staff President, and their subordinates or designees, the hospital's attorney and the hospital attorney's partners, assistants or designees, and all members of the Medical Staff who have any direct or indirect responsibility for obtaining or evaluating the applicant's or appointee's credentials and/or acting upon the applicant's or appointee's application or conduct in the hospital.

(7) As used in this section, the term "third parties" means all individuals or government agencies, organizations, associations, partnerships, corporations, whether hospitals, health care facilities or not, from whom information has been requested by the hospital and its authorized representatives, or who have requested such information from the hospital and its authorized representatives, provided that such request is received in good faith and pertains to the subject matter set forth in this section.

C. DESCRIPTION OF INITIAL CLINICAL PRIVILEGES

1. Application for Initial Clinical Privileges

a. Each physician, podiatrist and dentist who has been given privileges to practice in this hospital shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically approved by the Board, except for the provisions relating to temporary privileges. Clinical privileges represent authorization granted by the Board to provide specific patient care services in the hospital within defined limits based on an individual's license, education, training, experience, judgment and ability to perform the privileges granted.

b. Every initial application for staff appointment must contain, as a part thereof, a request for specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, ability to perform the privileges he or she has requested, references and other relevant information. The applicant shall have the burden of establishing his or her qualifications for and competence to exercise the clinical privileges requested, including his or her compliance with the requirements for such clinical privileges as set forth in the applicable clinical privilege description.

2. Clinical Privileges for Podiatrists and Dentists

    a. Podiatrists and dentists may, with the concurrence of a physician member of the Medical Staff and according to Medical Staff Policy, admit or discharge a patient. The general history and physical exam shall be the responsibility of that physician member of the staff. The podiatrist or dentist shall be responsible only for that part of the history and physical examination related to podiatry or dentistry.

    b. Patients admitted to the hospital for podiatric or dental care shall receive the same basic medical appraisal as patients admitted for other services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of the podiatric or dental patient.

3. Procedure for Initial Application

    a. Submission of Application

        (1) The completed application for Medical Staff appointment shall be submitted by the applicant. Failure to submit a completed application or to provide additional documentation or information necessary for processing the application when requested to do so will result in the application being considered inactive and the application will not be processed.

        (2) If any additional documentation or information requested is not provided within ninety (90) days of such request, the application will be considered null and void. Reapplication shall require payment of a new application fee.

    b. Medical Staff Department Procedure

        (1) The chief of each department to which the applicant will be assigned shall provide the Credentials Committee with recommendation for approving or disapproving the application and for delineating the applicant's clinical privileges.

        (2) These recommendations shall be made part of the Credentials Committee's report.

    c. Credentials Committee Procedure

        (1) The Credentials Committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including an appraisal from the chief of the clinical department to which the applicant will be assigned, whether the applicant has established and meets all of the necessary qualifications for the category of staff membership and clinical privileges requested.

        (2) After considering the recommendations of the Medical Staff departments concerning the applicant, the Credentials Committee shall make a written report and recommendation on the applicant to the Medical Staff Executive Committee.

        (3) As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss any aspect of the applicant's application, qualifications and clinical privileges.

4. Subsequent Action on the Application

a. At the next regular meeting of the Medical Staff Executive Committee after receipt of the Credentials Committee report, the Medical Staff Executive Committee shall consider the report and such other relevant information as is available and shall forward to the Board a written report and recommendation as to Staff appointment.

b. The Committee may also defer action on the application.
   (1) Upon Favorable Recommendation: When the recommendation of the Medical Staff Executive Committee is favorable to the applicant, the recommendation to appoint shall be reported at the next meeting of the Board. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions related to such clinical privileges.

   The Board shall adopt or reject a favorable recommendation of the Medical Staff Executive Committee, or refer the recommendation back to the Medical Staff Executive Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the Board's action is adverse to the applicant, the applicant shall be promptly notified by the Executive Director/CEO by certified mail, return receipt requested, and the applicant shall be entitled to the procedural rights as provided in the Fair Hearing Plan within these Bylaws.

   (2) Upon Deferral: When the recommendation of the Medical Staff Executive Committee is to defer the application for further consideration, it must be followed within ninety (90) days with a subsequent recommendation to the Board for appointment to staff membership with specified clinical privileges, or for rejection of the application for staff membership.

   (3) Upon Adverse Recommendation: When the recommendation of the Medical Staff Executive Committee is adverse to the applicant with respect to appointment or clinical privileges, the applicant shall be promptly notified by the Executive Director/CEO by certified mail, return receipt requested.

      (a) The following recommendations will be considered to adversely affect the practitioner's appointment to or status as a member of the Medical Staff or exercise of clinical privileges:
         i. Denial of initial appointment;
         ii. Denial of reappointment;
         iii. Revocation of appointment;
         iv. Denial of requested initial clinical privileges;
         v. Denial of requested increased clinical privileges;
         vi. Reduction of clinical privileges;
         vii. Revocation of clinical privileges;
         viii. Imposition of a mandatory concurring consultation requirement;
         ix. Suspension of clinical privileges;
         x. Denial of request for reinstatement following Leave of Absence.

      (b) No action, recommendation, or matter other than those enumerated in this section shall constitute grounds for hearing and appeal.

      (c) The application shall then be held until after the applicant has exercised or has been deemed to have waived the right to a hearing as provided in the Fair Hearing Plan within these Bylaws. At the time the applicant is deemed to have waived the right to a hearing, the recommendation of the Medical Staff Executive Committee

shall be forwarded to the Board.

(d) If the applicant requests a hearing, the initial report of the Medical Staff Executive Committee, the recommendation and hearing record, together with all supporting documentation, shall be forwarded to the Board.

(e) After Procedural Rights
   i. In the case of an adverse Medical Staff Executive Committee recommendation or an adverse Board decision, the Board shall take final action in the matter only after the applicant has exhausted or has waived the procedural rights as provided in the Fair Hearing Plan. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter back for further reconsideration.
   ii. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt.
   iii. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board shall make a final decision either to appoint the applicant to the Staff or to reject the applicant for Staff membership.

(4) Notice of Final Decision

(a) Notice of the Board's final decision shall be given to the President of the Staff and the Chairperson of the Credentials Committee, and to the applicant by means of certified mail, return receipt requested;

(b) A decision and notice to appoint shall include:
   i. The Staff category to which the applicant is appointed;
   ii. The clinical privileges the practitioner may exercise; and
   iii. Any special conditions attached to the appointment.

(5) Reapplication after Adverse Appointment Decision

(a) An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Staff for a period of two (2) years.

(b) Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the Staff or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.

5. Temporary Privileges

Temporary admitting and clinical privileges may be granted by the Executive Director/CEO and the President of the Medical Staff, upon the basis of information available, which may be reasonably relied upon as to the competence, character and ethical standing of the applicant and which indicates a favorable recommendation. At a minimum, primary source verification of licensure, education and training, current competence and malpractice insurance coverage is required prior to the granting of temporary privileges. In addition, the applicant must agree in writing to be bound by the Bylaws, Rules and Regulations, and Policies and Procedures of the hospital and Medical Staff.

a. Temporary Privileges for Applicants

Upon receipt of an application for Medical Staff membership from an appropriately licensed applicant, temporary admitting and clinical privileges may be granted. Temporary privileges granted shall remain in effect until action is recommended by the Credentials Committee and approved by the Board of Directors and shall not exceed ninety (90) days.

b. Temporary Privileges for Non-Applicant

(1) Locum Tenens

(a) Upon receipt of a written request, an appropriately licensed physician, who is serving as a locum tenens for a member of the Medical Staff or for a group which operates a department under a contractual arrangement may be granted temporary privileges as set forth in Article IV, Section C, Paragraph 5.

(b) Temporary privileges for locum tenens may be granted for an initial period of sixty (60) days. Such privileges may be renewed for two (2) successive periods of 30 days.

(2) Invited Expert

Upon receipt of a written request by a Member of the Medical Staff to allow a recognized expert in a specialty or subspecialty to participate in patient care at the hospital while providing education or training to a Member or Members of the Medical Staff, temporary privileges may be granted for the term of the request, which may not to exceed seven (7) days.

c. Temporary Privileges for Members

(1) Upon receipt of a request for increased clinical privileges by a member of the Medical Staff, the Executive Director/CEO and President of the Medical Staff may, based upon the information provided by the member justifying increased privileges, grant temporary increased clinical privileges to the member.

(2) The granting of temporary increased privileges shall specify a termination date for such temporary increased privileges, which shall be no more than sixty (60) days from the date granted.

d. Termination of Temporary Privileges

(1) Temporary privileges shall be granted for a specific period of time as warranted by the situation. Temporary privileges shall expire at the end of the time period for which they are granted.

(2) The Executive Director/CEO and the President of the Medical Staff may at any time, terminate an individual's temporary privileges effective as of the discharge from the hospital of all individual's patients under his or her care in the hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual, a summary termination of temporary privileges may be imposed and such termination shall be effective immediately.

(3) The President of the Medical Staff, or appropriate Department Chief, shall assign to a member of the Medical Staff responsibility for the care of such terminated individual's

patients until they are discharged from the hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute member of the Medical Staff.

(4) The granting of any temporary privileges is a courtesy on the part of the hospital and neither the granting, denial, nor termination of such temporary privileges shall entitle the individual concerned to any of the procedural rights provided in the Medical Staff Bylaws and Policies and Procedures with respect to hearings or appeals.

6. Emergency Action

a. In an emergency, any Medical Staff member to the degree permitted by his or her license and regardless of clinical privileges, shall be permitted to do, and shall be assisted in doing everything possible to save the life of a patient in the hospital, using every facility of the hospital necessary, including call for any consultation necessary or desirable.

b. When an emergency situation no longer exists, such staff member must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or the staff member does not request such privileges, the patient shall be assigned to an appropriate member of the Medical Staff.

c. For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to the patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

7. Disaster Privileging

a. Practitioners who do not currently possess medical staff membership and clinical privileges or Allied Health Professional membership may be processed and accepted to render patient care when the emergency management plan has been activated and the organization has determined that the assistance of additional medical professionals is necessary (Refer to the Disaster Privileging Policy in the Medical Staff Manual).

8. Resident in Training

a. Upon written request from the Director of Medical Education of an approved ACGME or AOA residency training program, a resident may be approved to observe and/or assist in patient care under the supervision of physician or podiatry preceptor. The requesting preceptor must be a member of the South Lake Hospital Medical Staff in good standing and be willing to accept the responsibility to supervise/evaluate the training of the resident.

b. In addition to the above, the Application for Resident Training Privileges must be completed and resident qualifications verified which include a valid Florida medical licensure and malpractice insurance coverage.

D. APPLICATION FOR REAPPOINTMENT

1. When Application is Required

a. Any member of the Medical Staff who wishes to be considered for reappointment, including a member on leave of absence, shall so indicate on the appropriate form. Any member of the Medical Staff who, at the time of processing reappointments to the Medical Staff, wishes to be considered for a change in Medical Staff category or a change in clinical privileges, or who does not desire reappointment, shall so indicate on the appropriate form. All members

of the Medical Staff who do not indicate otherwise shall be considered for reappointment to the same category of staff with the same clinical privileges they then hold. Reappointments to the Medical Staff shall be for a period of no more than two (2) years and shall automatically expire if not renewed as provided herein.

b. Each member of the Medical Staff who wishes to be reappointed shall be responsible for notifying the Credentials Committee of any material changes in the initial application, particularly with regard to the revocation or suspension of the staff member's professional license, or the imposition of terms of probation or limitation of practice by any state; or of a termination or suspension of the staff member's narcotic license, or of a loss, suspension, or probation of staff membership or privileges or any other professional competence or disciplinary action taken or pending against the staff member in any hospital, other health care institution, or professional society for any act which constitutes a violation of the provisions of the Florida Statues or the Florida Administrative Code, which regulate the staff member's practice; or the voluntary relinquishment of any licensure or registration (state or district, Drug Enforcement Administration) or voluntary limitation, reduction, or loss of clinical privileges at another hospital or health care institution; or of the commencement of a formal investigation, or the filing of a suit against the staff member alleging professional liability, or the settlement of any medical malpractice claim or litigation by the staff member or by anyone in the staff member's behalf, or of a conviction of or pleading nolo contendere to, any crime, including but not limited to a crime relating to health care; or of the exclusion from or ineligibility for participation on Federal or state health care programs; and shall, upon request, submit proof of state license.

2. Basis for Recommendations

Each recommendation concerning the reappointment of a Medical Staff member shall be based upon:

a. Such member's professional ethics, current clinical competence, and clinical judgment in the treatment of patients and the member's ability to perform the privileges requested;

b. Such member's participation in Medical Staff affairs;

c. Such member's compliance with the Hospital Bylaws, Policies and Procedures, Corporate Compliance Program, Code of Conduct, and the Medical Staff Bylaws, Rules and Regulations and Policies and Procedures;

d. Such member's cooperation with hospital personnel; and

e. Such member's use of the hospital facility for his or her patients, cooperation and relations with other practitioners, and general attitude toward patients, the hospital and the public.

f. All staff members shall be evaluated for reappointment on an individual basis after appropriate quality review.

g. No staff member shall be reappointed unless the staff member is a provider in good standing who has not been excluded from Federal and state healthcare programs and has not been convicted of a healthcare related crime.

3. Burden of Providing Information

a. The Medical Staff member who is applying for reappointment shall have the burden of providing adequate information for a proper evaluation of his or her current clinical

competence, clinical judgment, professional ethics, ability to perform the privileges requested, and other qualifications, and of resolving any doubts about such qualifications.

b. The member shall have the burden of providing evidence that all the statements made and information given on the application for reappointment and in support of the application are factual and true.

4. Medical Staff Department Procedure

   a. The chief of each department to which the applicant has been assigned shall provide the Credentials Committee with recommendation for approving or disapproving the application for reappointment and for delineating the applicant's clinical privileges.

   b. These recommendations shall be made part of the Credentials Committee's report.

5. Credentials Committee Procedure

   a. The Credentials Committee, after receiving recommendations from the Chief of each department, shall review all pertinent information available, including all information available from other committees of the Medical Staff and from hospital management for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing reappointment period.

   b. After the Credentials Committee has determined its recommendations, it shall make a written report on the applicants for reappointment to the Medical Staff Executive Committee.

   c. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated, documented and included in the report.

6. Meeting with Affected Member

   a. If, during the processing of a staff member's reappointment, it becomes apparent to the Credentials Committee or its chairperson that the committee is considering a recommendation that would deny reappointment, deny a requested change in clinical privileges, or reduce clinical privileges of any staff member, the chairperson of the Credentials Committee may notify the staff member of the general tenor of the possible recommendation, and ask the staff member if he or she desires to meet with the committee prior to any final recommendation by the committee.

   b. At such meeting, the affected staff member shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the policies and procedures with respect to hearings shall apply, nor shall minutes of the discussion in the meeting be kept. The committee shall indicate as part of its report to the Medical Staff Executive Committee whether such a meeting occurred.

7. Medical Staff Executive Committee Procedure

   a. The Medical Staff Executive Committee, after reviewing the report and recommendations of the Credentials Committee and all other relevant information, shall forward the Board of Directors its report and recommendation that appointment be renewed, renewed with modified staff category and/or clinical privileges, or terminated.

b. The committee may also defer action, provided that a recommendation is made prior to the member's reappointment date.

8. Procedure Thereafter

a. Any recommendation by the Medical Staff Executive Committee denying reappointment, denying a requested increase in clinical privileges, or recommending reduction in existing clinical privileges shall entitle the affected staff member to the procedural rights provided in the Fair Hearing Plan.

b. The staff member shall then be promptly notified by the Executive Director/CEO of the recommendation by certified mail, return receipt requested.

c. The recommendation shall not be forwarded to the Board until the applicant for reappointment has exercised or had been deemed to have waived the right to a hearing as provided in the Fair Hearing Plan, after which the Board shall be given the committee's final recommendation and shall act on it.

E. REQUESTS FOR MODIFICATION OF APPOINTMENT

1. A Staff member may, either in connection with reappointment or at any other time, request modification of Staff category or clinical privileges by submitting a written request to the Chairperson of the Credentials Committee.

2. Such application shall be processed in substantially the same manner as provided for reappointment.

F. LEAVE OF ABSENCE

1. Procedure for Leave of Absence

a. Members of the Medical Staff may be granted leaves of absence by the Board for a definitely stated period of time, not to exceed one (1) year or the remainder of the member's current term of appointment, whichever is shortest. Requests for leaves of absence shall be made to the Medical Staff Executive Committee and the Executive Director/CEO and shall state the beginning and ending dates of the requested leave and the reason leave is requested. The Medical Staff Executive Committee shall make a report and recommendation and transmit it to the Board.

b. No member may take more than one (1) consecutive one (1) year leave of absence. Leaves of absence are a matter of courtesy, not of right. In the event that a requested leave of absence is denied, or a leave of absence is granted for a shorter period of time than requested, the determination is final, with no recourse to any procedural rights. Leaves of absence are typically granted for reasons such as military duty, additional training, family matters, or personal health matters. Members who are relocating and who do not anticipate returning to this area are discouraged from requesting a leave of absence and should consider resignation.

2. Reinstatement Following Leave of Absence

a. A staff member who desires reinstatement following a leave of absence shall request reinstatement at least ninety (90) days prior to the termination of the leave of absence, by sending written notice to the Medical Staff Executive Committee and Executive Director/CEO, which shall refer the matter to the Credentials Committee for its

recommendation. The staff member shall submit a written summary of relevant activities during the leave.

b. The Credentials Committee shall make a recommendation to the Medical Staff Executive Committee and the Medical Staff Executive Committee shall make a recommendation to the Board concerning the reinstatement of the staff member's privileges.

3. Failure to Request Reinstatement

a. Failure to make a timely request for reinstatement or to provide a summary of activities shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership and privileges, without any further procedural rights.

b. A request for reinstatement subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointment, and will be subject to all requirements for initial appointment.

G. PHYSICAL AND MENTAL EXAMINATIONS OF MEDICAL STAFF MEMBER

1. When Examinations May Be Requested

a. Where appropriate, as a part of the delineation of clinical privileges (initial or increased), the reappointment process, reinstatement following leave of absence, or any investigation, the Credentials Committee, Medical Staff Executive Committee, or Investigation Committee may recommend that a Medical Staff member be required to procure an impartial physical or mental examination prior to making a recommendation on the member's request for clinical privileges, reappointment, or reinstatement, or on the investigation. Where procurement of an examination is recommended, the reasons for such examination shall be specified.

b. Each such recommendation will be addressed by the Board or its designee on an individual basis.

2. Scope of Examination

a. If a Medical Staff member is required to procure a physical and mental examination, the scope of the examination shall be specified by the Board or its designee.

b. The examination shall be conducted by an impartial physician agreeable to the Medical Staff member and the Board or its designee and the results shall be made available to the Board or its designee.

3. Failure to Procure Examination

Failure of the Medical Staff member to procure a required examination within a reasonable time, not to exceed sixty (60) days, after being required to do so in writing by the Board or its designee shall constitute a voluntary relinquishment of clinical privileges until such time as the examination is procured and, the results are provided in accordance with the specifications of the Board or its designee.

H. RESIGNATION

1. A member of the Medical Staff who wishes to resign must submit a letter of resignation to the

Medical Staff Executive Committee and Executive Director/CEO.

2. A member who does not complete all outstanding obligations (including, but not limited to, completion of medical records) will be considered to have resigned with prejudice.

ARTICLE FIVE

V. CORRECTIVE ACTION

A. ROUTINE CORRECTIVE ACTION

1. Criteria for Initiation

   Whenever the activity or professional conduct of any Staff member is believed to be detrimental to patient safety or to the delivery of quality patient care, or is reasonably probable of being disruptive to hospital operations, or is reasonably probable of being in violation of these Bylaws, Rules and Regulations or other Hospital policies, a request for corrective action against such Staff member may be initiated by any officer of the Staff or chief of any department or standing committee of the Staff, by the Executive Director/CEO, or by the Board of Directors.

2. Requests and Notices

   All requests for corrective action shall be type written, signed by all parties thereto, and submitted to the President of the Medical Staff. Such requests shall be supported by reference to the specific conduct or activity, which constitutes the grounds for the request. The President of the Medical Staff shall determine if the request will be handled by the Medical Staff Executive Committee or whether it will initially be referred to the Quality Review Committee. If it is to be handled by the Medical Staff Executive Committee, the President of the Medical Staff shall promptly notify the Executive Director/CEO and the President of the Board of Directors in writing of the request for corrective action. The Executive Director/CEO and the President of the Board of Directors shall be kept fully informed of all action taken in connection therewith.

3. Procedure

   a. If the request for corrective action is initially referred to the Quality Review Committee, the investigation will be considered to have begun upon referral. The Quality Review Committee will adhere to its procedure for case review, subject to the provisions of Article V, Section A, Paragraph 4 regarding interviews. Upon completion of its review, the Quality Review Committee shall provide a written report of its investigation and recommendations to the Medical Staff Executive Committee.

   b. If the request for corrective action is to be handled by the Medical Staff Executive Committee, the request shall be considered by the Medical Staff Executive Committee at its next meeting following receipt of the request. If, in the opinion of the Committee, the request contains sufficient information to warrant a recommendation, the Medical Staff Executive Committee may make one, subject to the provisions of Article V, Section A, Paragraph 4 regarding interviews. If the request does not at that point contain information sufficient to warrant a recommendation, the Medical Staff Executive Committee shall immediately appoint a subcommittee or an ad hoc committee to conduct an investigation (hereafter, the Investigation Committee). The Investigation Committee shall consist of at

least three (3) persons, and shall not include partners, associates, or relatives of the member being investigated. The Investigation Committee shall have the authority to review relevant documents and interview individuals with relevant information. It shall also have available to it the full resources of the Medical Staff and the hospital, as well as the authority to use outside consultants, if needed. The Investigation Committee shall provide a written report of its investigation and recommendations to the Medical Staff Executive Committee.

c. The investigation shall be completed and the written report and recommendation of the Quality Review Committee or Investigation Committee shall be submitted to the Medical Staff Executive Committee within a reasonable time. If the investigation cannot be completed within sixty (60) days, the Medical Staff Executive Committee shall be advised of the delay and the reasons therefor.

4. Interviews

a. When the Medical Staff Executive Committee is considering initiating an adverse recommendation concerning a Staff member without an investigation, the Staff member shall be notified by special notice and may request an interview. The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. At this meeting, (but not, as a matter of right, in advance of it), the Staff member shall be informed of the general nature of the evidence supporting the proposed adverse recommendation and shall be invited to discuss, explain, or refute it. A record of such interview shall be made either by tape recording or by abbreviated secretarial notes.

b. When the Medical Staff Executive Committee appoints an Investigation Committee to conduct an investigation, the Staff member who is under investigation shall be invited to meet with the Investigation Committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it), the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain, or refute it. This interview shall be informal in nature, shall not constitute a hearing, and shall not be conducted according to the procedural rules provided with respect to hearings. A record of the interview shall be made either by tape recording or by abbreviated secretarial notes.

c. When a request for corrective action is referred to the Quality Review Committee, the Staff member who is under investigation shall be invited to appear before the Medical Staff members of the Quality Review Committee before it makes its report. At this meeting, (but not, as a matter of right, in advance of it) the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain, or refute it. Any such appearance shall be informal in nature, shall not constitute a hearing and shall not be conducted according to the procedural rules provided with respect to hearings. A record of the interview shall be made either by tape recording or by abbreviated secretarial notes.

5. Medical Staff Executive Committee Action

a. At its next meeting following receipt of the Investigation Committee report or Quality Review Committee report, the Medical Staff Executive Committee shall take action upon the request. The Medical Staff Executive Committee may accept, modify, or reject the recommendation of the Investigation Committee or Quality Review Committee, or refer the matter back for additional information. Such action may include, without limitation:

(1) Rejecting or modifying the request for corrective action;

(2) Issuing a warning, a letter of admonition, or a letter of reprimand;

(3) Recommending terms of probation or a requirement for consultation;

(4) Recommending reduction, suspension or revocation of clinical privileges;

(5) Recommending that an already imposed suspension of clinical privileges be terminated;

(6) Recommending reduction of staff category or limitation of any Staff prerogatives directly related to patient care; or,

(7) Recommending suspension or revocation of Staff appointment.

b. The President of the Medical Staff shall inform the Board of the Medical Staff Executive Committee's decision.

6. Procedural Rights

a. Whenever the Medical Staff Executive Committee rejects a request for corrective action, the Executive Director/CEO and the Board shall have the option of proceeding with the investigation. Initiation of corrective action pursuant to Article V, Section A does not preclude imposition of summary precautionary suspension as provided in Article V, Section B.

b. Any recommendation by the Medical Staff Executive Committee pursuant to Article V, Section A, Paragraph 5, which is considered to adversely affect the Staff member as defined in Article XII, Section B, Paragraph 3 of these Bylaws shall entitle the staff member to the procedural rights as provided in Article XII of these Bylaws.

B. SUMMARY PRECAUTIONARY SUSPENSION

1. Criteria for Initiation

a. Whenever a Medical Staff member's conduct requires that immediate action be taken to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Hospital, or whenever the conduct of the Staff member materially disrupts the operation of the Hospital, the President of the Medical Staff, or the Executive Director/CEO, shall have the authority to suspend summarily the Staff appointment, or all or any portion of the clinical privileges of such Staff member. Such summary precautionary suspension shall become effective immediately upon imposition and shall remain in effect unless and until modified by the Medical Staff Executive Committee. A summary precautionary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that may be taken with respect to the suspended physician, podiatrist or dentist but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.

b. The President of the Medical Staff or the Executive Director/CEO shall communicate the suspension to the Staff member immediately, and shall within 48 hours give special notice of the suspension to the Staff member. The President of the Medical Staff or the Executive Director/CEO shall immediately report the suspension to the Medical Staff Executive

Committee.

2. Medical Staff Executive Committee Action

   a. The Medical Staff Executive Committee may recommend modification, continuation, or termination of the terms of the summary precautionary suspension.

   b. The Medical Staff Executive Committee shall take such further action as is required in the manner specified under Article V, Section A. The review of the matter resulting in precautionary suspension shall be completed within a reasonable time or reasons for the delay shall be transmitted to the Executive Director/CEO so that the Executive Director/CEO or Medical Staff Executive Committee may consider whether the suspension should be lifted.

3. Procedural Rights

   a. Unless the Medical Staff Executive Committee recommends immediate termination of the suspension and cessation of all further corrective action, the Staff member shall be entitled to the procedural rights as provided in Article XII and the matter shall be processed in accordance with the provisions of Article XII.

   b. The terms of the summary precautionary suspension as sustained or as modified by the Medical Staff Executive Committee shall remain in effect pending a final decision by the Board of Directors.

C. AUTOMATIC SUSPENSION

1. License

   If a Staff member's professional license to practice in the State of Florida is revoked or suspended, such Staff member shall immediately and automatically be suspended from practicing in the Hospital.

2. Drug Enforcement Administration (DEA) Number

   a. A Staff member whose DEA number is revoked or suspended or voluntarily relinquished shall immediately and automatically be divested of the right to prescribe medications covered by such number.

   b. As soon as reasonably possible after such automatic suspension, the Medical Staff Executive Committee shall convene to review and consider the facts under which the DEA number was revoked or suspended or relinquished.

   c. The Medical Staff Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in its investigation.

3. Special Appearance

   a. Any practitioner, whose clinical care of a patient is questioned as to appropriateness by a committee of the Medical Staff because of apparent or suspected deviation from standard clinical practice, is subject to an appearance before the Quality Review Committee. Special written notice shall be given to the practitioner of the time and place of the meeting at least three (3) days prior to the meeting. The notice shall include a statement of the issue involved and that the Staff member's appearance is mandatory.

b. Failure of a Staff member to appear at any meeting with respect to which the Staff member was given such special notice shall, unless excused by the Medical Staff Executive Committee upon a showing of good cause, result in an automatic suspension of all or such portion of the Staff member's clinical privileges as the Medical Staff Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Staff Executive Committee, or the Board, or through corrective action if necessary.

4. Conviction of a Felony

a. Upon exhaustion of appeals after conviction of a felony of a Staff member in any court in the United States, either federal or state, the member's Staff appointment is automatically revoked. Revocation pursuant to this section of the Bylaws does not preclude the Staff member from subsequently applying for Staff appointment.
b. The filing of criminal charges, a no contest plea, or a finding of guilt by a court of record may constitute sufficient basis for investigation by the Medical Staff Executive Committee.

5. Medical Records

a. Medical records of discharged patients shall be completed as soon as possible after the time of discharge and filed in the permanent medical record within thirty (30) days of discharge.

b. The clinical privileges of any Medical Staff Member shall be temporarily voluntarily relinquished for failure to complete medical records in accordance with the applicable standards of practice and rules after notification to the Medical Staff Member by the Executive Committee in accordance with this section of the Bylaws.

c. For the purpose of enforcing this section, Article V, Section C, Paragraph 5, justified reasons for delay in completing medical records shall include, without limitation:

(1) That the Staff member or any other individual contributing to the record is ill, on vacation, or otherwise unavailable for a period of time;

(2) That the Staff member is waiting for the results of a late report and the record is otherwise complete except for the discharge summary and final diagnosis;

(3) That the Staff member has dictated reports and is waiting for hospital personnel to transcribe them;

(4) That the Staff member has not received written notice sent by certified mail within seven (7) days prior to the date the suspension would be imposed due to records requiring completion.

6. Effect of Above Actions

The above actions concerning staff members shall not be considered professional review actions and shall not entitle the individual concerned to any of the procedural rights provided in these Bylaws.

D. CONTINUITY OF PATIENT CARE

1. Upon the imposition of summary precautionary suspension or the occurrence of an automatic suspension, the President of the Staff shall provide for alternative coverage of the suspended

Staff member's patients in the Hospital.

2. The wishes of the patient shall be considered where feasible in choosing a substitute practitioner.

3. The suspended Staff member shall confer with the substitute practitioner to the extent necessary to safeguard the patient.

E. PROTECTION FROM LIABILITY

1. In matters relating to peer review and corrective action, all Medical Staff members, all Hospital personnel, all members of the Hospital Board of Directors, the Executive Director/CEO, and hospital counsel shall be acting pursuant to the same rights, privileges, immunity and authority as provided in Article XII, Section O, Paragraph 6 of these Bylaws.

2. Each practitioner subject to peer review and corrective action acknowledges the authority and immunity granted to such persons in carrying out their duties in peer review and corrective action and hereby releases such persons from all liability for their actions done in good faith without intentional fraud.

ARTICLE SIX

VI. ORGANIZATION OF THE MEDICAL STAFF

A. MEDICAL STAFF YEAR

For the purpose of these Bylaws, the Medical Staff year commences on the 1st day of October and ends on the 30th day of September each year.

B. QUALIFICATIONS OF OFFICERS, DEPARTMENT CHIEFS, VICE-CHIEFS AND COMMITTEE CHAIRPERSONS

1. In order to be eligible to serve as a Medical Staff officer, department chief, department vice-chief and committee chairperson, a Medical Staff member must:

    a. Be appointed in good standing to the Active Staff and continue to do so during his or her term of office;

    b. Be certified by an appropriate specialty board;

    c. Have demonstrated interest in maintaining quality medical care at the hospital;

    d. Have constructively participated in Medical Staff affairs, including peer review activities;

    e. Be knowledgeable concerning the duties of the position to which he or she is elected or appointed;

    f. Be willing to discharge faithfully the duties and responsibilities of the position to which he or she is elected or appointed;

    g. Comply with South Lake Hospital's conflict of interest policy.

2. All Medical Staff Officers, department chiefs and department vice-chiefs, and committee chairpersons must possess at least the above qualifications and maintain such qualifications during their term of office. Failure to do so shall automatically create a vacancy in the office involved.

3. Additional Qualifications for Officers

    It is recommended that, in addition to meeting the above requirements, a member should have

previously served as department chief, department vice-chief, or chairperson of a Medical Staff committee.

C. OFFICERS OF THE STAFF

The officers of the Staff shall be the President, Vice-President and Secretary/Treasurer. At the time of nomination and election and at all times during their term of office, officers must be members of the Active Medical Staff, who meet the requirements for all officers, department chiefs, department vice-chiefs and committee chairpersons. Failure to maintain such status shall immediately create a vacancy in the office involved.

Officers of the Medical Staff Executive Committee may not simultaneously serve as committee chairpersons.

1. President

   The President shall serve as the chief administrative officer and principal elected official of the Staff. As such, the President shall:

   a. Act on behalf of the Medical Staff in coordination and cooperation with the Executive Director/CEO in matters of mutual concern involving the hospital as the chief medical officer of the hospital;

   b. Represent the views, policies, needs and grievances of the Medical Staff to the Executive Director/CEO and to the Board, including the attendance of Board meetings;

   c. Serve as chairperson of the Medical Staff Executive Committee and as an ex-officio member of all other Staff committees;

   d. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

   e. Appoint committee members, who shall serve at the pleasure of the President, to all standing, special and multi-disciplinary Medical Staff committees, except the Medical Staff Executive Committee;

   f. Be accountable to the Board, in conjunction with the Medical Staff Executive Committee, for the quality and efficiency of clinical services and performance within the Hospital, and for the effectiveness of the review and evaluation of patient care and other quality review functions delegated to the Staff;

   g. Develop and implement, in cooperation with committee chairperson, methods for credentials review and for delineation of privileges, continuing education programs, utilization management, concurrent monitoring of practice, and quality review activities;

   h. Be responsible for the enforcement of these Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

   i. Serve as the spokesman of the Staff in its external professional and public relations.

2. Vice-President

The Vice-President shall:

a. Be a member of the Medical Staff Executive Committee;

b. Assume all the duties and have the authority of the President in the absence of the President;

c. Shall perform such additional duties as may be assigned by the President.

3. Secretary/Treasurer

The Secretary/Treasurer shall:

a. Be a member of the Medical Staff Executive Committee
b. With the assistance of the Medical Staff Office:

(1) Keep records of all meetings of the Medical Staff and Medical Staff Executive Committee, including;

(2) Supervise the collection and accounting for any funds that may be collected in Staff dues, assessments, or application fees, and maintain proper records of such funds; such monies are to go into a Medical Staff fund and shall be used at the discretion of the Medical Staff Executive Committee with fifty percent (50%) vote.

(3) Make disbursements from Medical Staff funds (if any) as authorized by the Medical Staff Executive Committee and in accordance with applicable Hospital and Medical Staff Policies and Procedures;

a) Sign all checks distributed from the Medical Staff account;

b) Checks for amounts of $1,000 or more must be co-signed by President.

(4) Render an annual report.

(5) Perform such other duties as pertain to this office.

4. Term of Office

a. The term of office for Medical Staff officers shall be two (2) years, commencing on the first day of the Medical Staff year following the election. Each officer shall serve until the end of the term or until a successor is elected.

b. The officers of the Staff shall serve no more than two (2) consecutive terms in the same office and each is not eligible again for election to an office which has been held for such period for two (2) years after the Medical Staff member has ceased to hold such office.

7. Vacancies in Offices

a. Vacancies in offices, other than that of President, shall be filled by the Medical Staff Executive Committee.

b. If there is a vacancy in the office of President, the Vice-President shall become President and serve out the remaining term.

8. Removal of Officers

    a. An officer shall be removed from office if a two-third's (2/3's) majority of the Active Staff vote in favor of removal and the Medical Staff Executive Committee and Board concur. Grounds for removal shall include, but not be limited to, mental and/or physical impairment and inability and/or unwillingness to perform the duties and responsibilities of the office.

    b. Action directed toward removing an officer from office may be initiated by submission to the Medical Staff Executive Committee of a petition seeking removal of an officer, signed by not less than fifty percent (50%) of the Active Staff with voting rights.

    c. A meeting of the Active Staff shall be called within fourteen (14) days of receipt of the petition.

9. Election of Officers

    a. Officers shall be elected every two (2) years at the annual meeting of the Staff. A nominee shall be elected upon receiving a majority of the votes cast by secret written ballot of those present or by absentee ballot.

    b. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two (2) candidates receiving the highest number of votes.

10. Nominations

    a. By Nominating Committee

        (1) In each election year, the President of the Medical Staff shall appoint a Nominating Committee of three (3) Active Staff members.

        (2) The Nominating Committee shall submit to the Secretary of the Staff a list of one (1) or more qualified nominees for each office who have agreed to stand for election.

    b. By Other Means

        (1) Qualified nominees, in addition to those presented by the Medical Staff Executive Committee, may be made by Active Staff members.

        (2) Nominations must be signed by the person(s) making the nominations and by the person nominated signifying his or her acceptance of the nomination and be submitted to the President no later than twenty-one (21) days prior to the election.

    c. The names of nominees, those presented by the Nominating Committee and by other means, shall be reported to the Staff by the Medical Staff Executive Committee at least fifteen (15) days prior to the annual meeting.

    d. If the Medical Staff Executive Committee presents a single nomination and there are no other nominees by other means, the unopposed candidates shall be deemed to be elected and no election will be held.

ARTICLE SEVEN

VII. MEDICAL STAFF DEPARTMENTS

A. Organization of Medical Staff Departments

1. The Medical Staff shall be divided into departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chief who is elected by the members of the department and entrusted with the authority and responsibility for all activities, administrative and medical, occurring within the department and must account for departmental performance.

2. The Department Chief will be a member of the Medical Staff Executive Committee and shall be directly accountable to the President of the Medical Staff.

B. Designation

1. The Medical Staff shall be organized into two (2) Clinical Departments, Medicine and Surgery.

2. Each department is divided into sections, each of which is directly responsible to the department within which it functions.

   a. Sections

      (1) Department of Medicine

Allergy & Immunology	Internal Medicine
Cardiology	Nephrology
Dermatology	Neurology
Emergency Medicine	Pediatrics
Family Medicine	Psychiatry
Gastroenterology	Pulmonary Disease
Hematology/Oncology	Radiation Oncology
Infectious Disease	Radiology

      (2) Department of Surgery

Anesthesia	Pain Management
General Surgery	Pathology

Neurosurgery
OB/GYN
Ophthalmology
Oral & Maxillofacial Surgery
Orthopedics
Otolaryngology
Peripheral Vascular Surgery
Plastic Surgery
Podiatry
Thoracic Surgery
Urology

b. It is recognized that in the future, departments and sections may, as deemed appropriate, be created, eliminated, subdivided, or combined by amendments to the Bylaws.

C. Assignment to Medical Staff Department

1. Each member of the Medical Staff shall be assigned to one (1) department, which assignment will be based on appropriate training and experience, but may also be granted clinical privileges in one (1) or more additional department(s).
2. The exercise of clinical privileges within each department shall be subject to the rules and regulations therein; the authority of the Chief of the respective department, and as specified by these Bylaws and Medical Staff Rules and Regulations.

D. Functions of the Medical Staff Department

1. The primary responsibility delegated to each staff department is to implement and conduct specific review and evaluation activities that contribute to the maintenance, improvement of quality and efficiency of patient care provided within that department.

2. To carry out this responsibility, each department will:

a. Monitor, evaluate and make recommendations for maintaining and improving the quality of care provided within the department;

b. Recommend guidelines for granting of clinical privileges and clinical duties within the department.

c. Monitor on a continuing basis, adherence to:

(1) Medical Staff Bylaws, Rules & Regulations, and Hospital Policies and Procedures;

(2) Requirements for alternate coverage and for consultations;

d. Coordinate the patient care provided by department members with nursing and ancillary patient care services and administrative support services;

e. Establish and maintain processes for staffing the emergency department call schedule and unassigned inpatient consultations.

f. Meet at least quarterly.

g. Perform such other responsibilities as are assigned by these Medical Staff Bylaws, Rules and Regulations.

E. Creation and Dissolution of Departments

An amendment to these Bylaws shall be required to create or dissolve a Medical Staff Department.

F. Functions of the Department Chief and Vice-Chief

1. Each Department Chief shall:

   a. Be responsible for the organization of all Medical Staff activities of the department and for the general administration of the department, including but not limited to assigning members of the department functions and responsibilities including, where appropriate, service patients, emergency service care and consultation, unassigned inpatient consultations and participating in peer review;

   b. Be a member of the Medical Staff Executive Committee;

   c. Maintain continuing review of the professional performance of all individuals with clinical privileges in the department and report and recommend thereon to the Medical Staff Executive Committee. Be responsible for continuous assessment and improvement of the quality of care, treatment, and services.

   d. Be responsible for implementation within the department of the Hospital Bylaws, the Medical Staff Bylaws, Policies and Procedures, Rules and Regulations, the Department Rules and Regulations, and the Performance Improvement Plan;

   e. Be responsible for implementation within the department of actions taken by the Medical Staff Executive Committee;

   f. Transmit to the Credentials Committee the recommendations concerning the appointment, reappointment, provisional review and delineation of clinical privileges for all individuals designated to the department;

   g. As applicable, be responsible for the establishment, implementation, and effectiveness of the education in the department.

   h. Be responsible for all clinically related activities of the department.

   i. Be responsible for administratively related activities of the department, unless otherwise provided by the hospital.

   j. 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 organization.

   k. Be responsible for the integration of the department or service into the primary functions of the organization.

   l. Be responsible for the coordination and integration of interdepartmental or intradepartmental services.

   m. Develop and implement policies and procedures that guide and support the provision of care, treatment, and services.

   n. Make recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

   o. Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and

services.

p. Be responsible for the maintenance of quality control programs, as appropriate.

q. Be responsible for the orientation and continuing education of all persons in the department or service.

r. Recommend space and other resources needed by the department or service.

2. A Vice-Chief may be elected by each department to assist in the overall functions of the Department as assigned by the Department Chief as he or she deems appropriate. In the temporary absence of the Department Chief, the Vice-Chief will assume all duties and functions of the department.

G. Selection and Tenure of Department Chief and Vice-Chief

1. Each Department Chief and Vice-Chief shall be elected at the respective Department meeting prior to the annual meeting of the Medical Staff by a majority of votes of eligible, active membership present and by absentee ballot. The candidate receiving the majority of votes and duly elected must be confirmed by the Medical Staff Executive Committee and the Board of Directors.

2. The term of the Department Chief and Vice-Chief shall be two (2) years and consecutive terms shall not be permitted.

H. Removal of Department Chief and Vacancies

1. The members of a Department may hold a recall election to remove their Department Chief or Vice-Chief upon presentation of a petition signed by a majority of the Active Staff members within the Department to the Medical Staff Executive Committee.

2. Such removal shall require two-thirds (2/3) vote of the entire voting membership of Active Staff members within the Department, present or by absentee ballot and the approval of the Medical Staff Executive Committee. The affected Department Chief shall not be permitted to vote on removal at the Executive Committee.

3. A vacancy for a Department Chief or Vice-Chief shall be filled as soon as possible in the same manner as set forth in Article VII, Section G above for the remaining term.

ARTICLE EIGHT

VIII. COMMITTEES OF THE MEDICAL STAFF

A. DESIGNATION

There shall be such standing and special committees of the Staff as may from time to time be necessary and desirable to perform the functions of the Staff required by these Bylaws or necessarily incidental thereto.

B. STRUCTURE

1. Tenure of committee appointments is two (2) years.

2. Chairpersonship of any committee may be changed within the two (2) year period at the discretion of the Medical Staff Executive Committee.

    a. Chairpersons

    Appointment of all committee chairpersons, unless otherwise provided for in these Bylaws, will be approved by the Board upon receiving recommendations from the President. All chairpersons must meet the requirements in Article VI, Section B.

    b. Members

    Members of each committee, except as otherwise provided for in these Bylaws, shall be appointed by the President.

    c. Ex-Officio

    (1) The Executive Director/CEO of the hospital or his or her designee attends each executive committee meeting on an ex-officio basis, without vote.

    (2) All Hospital personnel, other than Staff members, to serve on committees shall be appointed by the Executive Director/CEO.

    (3) The President of the Staff may appoint Staff members to other Hospital-wide committees as requested by the Executive Director/CEO.

C. FUNCTION

1. All committees shall:

    a. Maintain a record of attendance at their meetings;

    b. Submit timely reports of their activities and copies of the minutes of their meetings to the Medical Staff Executive Committee;

    c. Conform in their proceedings and actions with the relevant provisions of Article VIII.

2. Staff committees are defined as follows:

    a. Medical Staff Executive Committee, Bylaws and Rules Committee, Credentials Committee, and Quality Review Committee.
    b. Medical Staff members may also be appointed by the President of the Medical Staff to serve actively in the review of hospital functions, which may conduct business in committee format. These shall include: medical records review, pharmacy and therapeutics review, surgical case/blood utilization review, and radiation safety. Others shall include critical care, emergency services, ethics, and infection control. Reports of these functions and activities shall be submitted to the Quality Review Committee on a quarterly basis.

D. MEDICAL STAFF EXECUTIVE COMMITTEE

1. There shall be a Medical Staff Executive Committee composed of the following individuals:

    a. Officers of the Medical Staff Executive Committee

        (1) President

        (2) Vice-President

        (3) Secretary/Treasurer

    b. Chief of the Department of Medicine;

    c. Chief of the Department of Surgery;

    d. Chairpersons of the following committees

        (1) Bylaws, Rules and Regulations

        (2) Credentials

        (3) Quality Review.

2. The majority of voting Medical Executive Committee members are fully licensed doctors of medicine and osteopathy of any discipline or specialty actively practicing in the hospital.

3. The President shall be chairperson of the Medical Staff Executive Committee. The President shall attend the meetings of the Board to present recommendations on all matters within the scope of the Medical Staff Executive Committee's duties and to increase direct communication between the Board and the Medical Staff Executive Committee.

4. The Medical Staff Executive Committee is empowered to act for the Medical Staff during the intervals between meetings.

5. The duties of the Medical Staff Executive Committee shall be to:

    a. Coordinate the activities and general policies adopted by the Staff and committees;

    b. Receive and act upon reports of Medical Staff committees, departments and assigned activity groups on the overall results of review and evaluation of patient care and other quality review activities of the Staff and on the fulfillment of the other required staff functions and make recommendations concerning them to the President and the Board;

    c. Take all reasonable steps to ensure professionally ethical conduct and to enforce hospital and Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures in the best interest of patient care and of the hospital on the part of all members of the Medical Staff;

    d. Make recommendations to the Medical Staff regarding amendment to the Bylaws, Rules & Regulations and Staff Policies and Procedures;

    e. Make recommendations directly to the Board regarding Medical Staff structure, the mechanism used to review credentials and to delineate individual clinical privileges, the mechanism by which Medical Staff membership may be terminated, and the mechanism for fair hearing procedures;

    f. Make recommendations directly to the Board relating to appointments, reappointments, staff category, department assignments, clinical privileges, and corrective action;

    g. Implement policies of the Medical Staff, which are not the responsibility of the Medical Staff departments or hospital;

    h. Provide liaison among Medical Staff;

    i. Refer situations involving questions of the clinical competence, patient care and treatment or patient management of any individual members of the Medical Staff to the appropriate committee for appropriate investigation and recommendation and Initiate and pursue corrective action, as warranted and in accordance with these Bylaws;

    j. Make recommendations on medico-administrative and Hospital management matters to the Board through the Executive Director/CEO;

    k. Ensure that the Medical Staff is kept abreast of the Joint Commission on Accreditation of Healthcare Organizations accreditation program and informed of the accreditation status of the hospital;

    l. Participate with the Board and Executive Director/CEO in establishing, reviewing, and revising the strategic directives for the organization;

    m. Elect and appoint representatives to Staff committees and hospital functions, when required by these Bylaws;

    n. Meet monthly or as often as necessary to conduct business at a regularly scheduled date and time;

o. Review and approve a listing of those clinical services with which the Hospital contracts.

5. Recommendations of the Medical Staff Executive Committee shall be transmitted to the Executive Director/CEO and the Board. The President shall attend the meetings of the Board to increase direct communication between the Board and the Medical Staff Executive Committee.

E. BYLAWS AND RULES COMMITTEE

1. There shall be a Bylaw and Rules Committee composed of at least three (3) members of the Active Medical Staff. The duties of the Bylaw and Rules Committee shall be to:

   a. Review, rewrite and put into form all proposed amendments or revisions to the Bylaws or Rules and Regulations, Staff Policies and Procedures;

   b. Present all recommendations for amendments or revisions to the Medical Staff Executive Committee for approval.

The Committee shall meet as often as necessary to conduct business or annually.

F. CREDENTIALS COMMITTEE

1. There shall be a Credentials Committee composed of at least five (5) members of the Active Medical Staff. The duties of the Committee shall be:

   a. To review the credentials of all applicants, to make such investigations and interview all applicants as may be necessary, and to make recommendations for appointment and delineation of clinical privileges in compliance with these Bylaws;

   b. To make a report to the Medical Staff Executive Committee on each applicant for Medical Staff membership or clinical privileges, including specific consideration of the recommendations from the department to which the applicant will be assigned;

   c. To review the Delineation of Clinical Privileges of each specialty and make recommendations thereon to the Medical Staff Executive Committee;

   d. To review periodically on its own motion or as questions arise all information available regarding the professional and clinical competence of staff members, their care and treatment of patients, and, as a result of such review, to make recommendations to the Medical Staff Executive Committee for the granting, reduction, or withdrawal of privileges, the elevation to non-provisional staff status or extension of provisional status at the end of the provisional period, reappointments, and modification of staff appointment;

   e. To review the Position Descriptions for Allied Health Personnel and to make recommendations thereon to the Medical Staff Executive Committee.

2. The Committee shall meet as often as necessary to conduct business or at least six (6) times per year.

G. QUALITY REVIEW COMMITTEE

1. There shall be a Quality Review Committee composed of at least five (5) members of the Active Staff, which shall include a representative from the Department of Medicine and Department of Surgery. The duties of the Quality Review Committee shall be to:

   a. Receive and review reports concerning the care of patients to include the review of medical

records, pharmacy and therapeutics, invasive procedures, blood utilization, and radiation safety, critical care, emergency services, ethics, and infection control. These reviews are used to identify opportunities for improvement, measurement of outcomes and processes and evaluation of staff members with privileges whose performance is questioned as a result of measurement and assessment reviews;

b. Recommend action concerning the improvement of quality of care to the Medical Staff Executive Committee;

c. Upon referral from the President of the Medical Staff in accordance with Article V**,** conduct case review and report to the Medical Staff Executive Committee.

2. The Committee shall operate according to the guidelines as defined in the Performance Improvement/Patient Safety Plan which is presented to Medical Staff Executive Committee for approval on an annual basis. The Committee shall also be composed of representation from hospital administration, the quality review department, and the nursing department. The Committee shall meet as often as necessary to conduct business or at least every other month.

ARTICLE NINE

IX. MEETINGS OF THE MEDICAL STAFF

A. PROVISIONS COMMON TO ALL MEETINGS

1. Manner of Action

   Except as otherwise specified in these Bylaws, the action of a majority of the members voting at a meeting at which a quorum is met, either present or by absentee ballot, shall be the action of the group.

2. Minutes

   Minutes of each meeting of each committee and department shall be prepared and shall include a record of the attendance of members, of the recommendations made, and of the votes taken on each matter. The minutes shall be signed by the presiding officer, approved by the attendees, forwarded to the Medical Staff Executive Committee, and made available to the Staff. A permanent file of the minutes of each meeting shall be maintained by each committee and each department.

B. ATTENDANCE REQUIREMENTS

1. Each member of the Active Medical Staff is required to attend at least fifty percent (50%) of all meetings of each department or committee to which he or she has been assigned or appointed.

2. Failure to meet the attendance requirements shall result in the loss of eligibility to vote on staff matters.

3. A staff member whose clinical care of a patient is scheduled for discussion at a department or committee meeting shall be so notified and shall be required to attend such meeting.

C. GENERAL STAFF MEETINGS

1. Annual Staff Meetings

   There shall be an Annual meeting of the Medical Staff.

2. Notice of Meeting

   Written or oral notice of the place, day and hour of such meeting shall be given to each member of the Medical Staff no less than seven (7) days before the time of the meeting.

3. Agenda

   The order of business at any Medical Staff meeting shall be at the discretion of the President of the Staff.

4. Quorum

   a. The presence of twenty percent (20%) of the voting members of the Active Staff shall constitute a quorum for transaction of all regular business, excluding the amendment of Bylaws, Rules and regulations.

   b. In the event that it is necessary for the Medical Staff to act on a question without being able to meet, the voting members may be presented with the question by mail from the Medical Staff Executive Committee and their votes returned to the Medical Staff Office by mail.

5. Special Medical Staff Meetings

   a. Special meetings of the Staff may be called at any time by the President of the Staff, the Medical Staff Executive Committee, the Board, or by the President of the Staff within five (5) days after receipt of a written request of at least fifty percent (50%) of the members of the Active Staff, and shall be held at the time and place designated in the meeting notice. In the event that it is necessary for the Staff to act on a question without being able to meet, the voting members may be presented with a question by mail and their votes returned to the Medical Staff Office.

   b. A written notice stating the place, day, hour and purpose of any special meeting of the Medical Staff shall be given to each member of the staff eligible to vote not less than fourteen (14) days before the date of such meeting. The notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to each Staff member at the member's address as it appears on the records of the hospital or when transmitted by facsimile or e-mail to the member's facsimile or e-mail address as they appear on the records of the hospital. No business shall be transacted at any special meeting except that stated in the meeting notice.

D. DEPARTMENT AND COMMITTEE MEETINGS

1. Department

   Members of each department shall meet as a department at times set by the chief of the department to draw conclusions, formulate recommendations, and initiate actions based on the findings of the department's monitoring and evaluation activities and to discuss other matters concerning the department.

2. Committee

   Medical Staff Committees shall hold regular meetings at a time and place designated by written notice of the Chairperson. The frequency of such meetings shall be as required by these Bylaws.

3. Notice of Meeting

   Written or oral notice of the place, day and hour of such department or committee meeting shall be given to each member of the department no less than seven (7) days before the time of the meeting.

4. Agenda

   The agenda for the meeting and their general conduct shall be set by the department chief or committee chairperson.

5. Quorum

   a. Medical Staff Executive Committee

      The presence of fifty-one percent (51%) of the voting members of the Medical Staff Executive Committee shall constitute a quorum for transaction of all regular business, excluding the amendment of Bylaws, Rules and Regulations.

   b. Other Medical Staff Committees

      Twenty percent (20%) of the voting members of a department shall constitute a quorum at any meeting of such committee or department. Ex-officio members shall not be counted in determining the presence of a quorum.

6. Special Department and Committee Meetings

   a. A special meeting of any department or committee may be called by, or at the request of, the department chief or committee chairperson, by the President of the Medical Staff or by the department chief or committee chairperson within five (5) days after receipt of a written request of at least fifty percent (50%) of the department or committee's current members. In the event that it is necessary for a department or committee to act on a question without being able to meet, the voting members may be presented with a question by mail and their votes returned to the Medical Staff Office.

   b. A written notice stating the place, day, hour and purpose of any special meeting of a department or committee shall be given to each member not less than fourteen (14) days before the date of such meeting. The notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to each member at the member's address as it appears on the records of the hospital or when transmitted by facsimile or e-mail to the member's facsimile or e-mail address as they appear on the records of the hospital. No business shall be transacted at any special meeting except that stated in the meeting notice.

ARTICLE TEN

X. GENERAL PROVISIONS

A. MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff Executive Committee, with the approval of the Board, shall adopt Rules and Regulations as may be necessary to implement more specifically the general principles of conduct found in these Bylaws. The Rules and Regulations shall set standards of practice that are to be required of each physician, podiatrist and dentist in the hospital and shall act as an aid to evaluate performance under, and in compliance with, these standards. Rules and regulations shall have the same force and effect as the Bylaws.

1. Procedures for Adoption and Amendments of Rules and Regulations

A. Adoption and amendment of the Rules and Regulations may be recommended to the Board by the Medical Staff Executive Committee after a majority vote, provided that the proposed adoption or amendment of any rule or regulation shall first be distributed to the members of the medical staff for review and comment.

(a) A rule or regulation, or amendment thereto, proposed by the Medical Executive Committee, shall be distributed to the members of the Medical Staff by mail, facsimile transmission, or by e-mail at least fourteen (14) days prior to the Medical Executive Committee vote, together with instructions on how interested members may communicate comments.

(b) All comments shall be summarized and provided to the Medical Executive Committee prior to Medical Executive Committee action on the proposed rule, regulation, or amendment thereto.

B. Rules and regulations, and amendments thereto, may also be proposed to the Board by the medical staff by majority vote of the voting members of the medical staff. Proposed rules and regulations and amendments thereto may be brought before the voting members of the medical staff by petition signed by at least a simple majority of voting members. Before any such proposed rule or regulation or amendment thereto is voted on by the voting members of the medical staff, it shall first be submitted to the Medical Executive Committee at the next meeting of the Medical Executive Committee for review and comment. The Medical Executive Committee's

recommendation with respect to the proposed rule and regulation or amendment may accompany the ballot, which may be written or electronic.

C. In the event of a conflict between the Medical Executive Committee and the medical staff regarding the adoption of any rule and regulation, or any amendment thereto, the matter may be submitted to the conflict management process in Article Eleven.

D. Following approval by the Medical Executive Committee or the voting members of the medical staff as described above, a proposed rule, regulation, or amendment thereto, shall be forwarded to the Board. The Medical Executive Committee may forward to the Board its comments on any rule and regulation or amendment approved by the voting members of the medical staff. Rules and regulations and amendments thereto shall become effective when approved by the Board.

2. Procedure for Urgent Amendment of Rules and Regulations

In the event of a documented need for an urgent amendment to rules and regulations necessary to comply with a federal, state, or local law or regulation, the Medical Executive Committee is authorized to provisionally adopt an urgent In the event of a documented need for an urgent amendment to rules and regulations necessary to comply with a federal, state, or local law or regulation, the Medical Executive Committee is authorized to provisionally adopt an urgent amendment and forward it to the Board for approval and immediate implementation, without prior notification of the medical staff. In such event, the medical staff shall immediately be notified of the provisionally-adopted and approved amendment and shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Executive Committee and the voting members of the medical staff, the amendment stands. If there is conflict over the provisional amendment, as indicated by a petition signed by a simple majority of voting members of the medical staff, the Conflict Management Process in Article Eleven shall be implemented.

3. Notification Regarding Rules and Regulations

Notification of adoption of rules and regulations and amendments thereto shall be distributed to the medical staff by posting on the medical staff pages of the hospital website, publication in the medical staff newsletter or other means of notification, including but not limited to, mail, facsimile transmission, or e-mail.

B. MEDICAL STAFF POLICIES AND PROCEDURES

The Medical Staff Executive Committee, with the approval of the Board, shall adopt Medical Staff Policies and Procedures that further define the general policies contained in these Bylaws. Policies and Procedures shall have the same force and effect as the Bylaws.

1. Procedure for Adopting and Amending Policies and Procedures

A. The Medical Executive Committee may recommend the adoption or amendment of policies and procedures to the Board after a majority vote.

B. Policies and procedures, and amendments thereto, may also be proposed to the Board by the medical staff by majority vote of the voting members of the medical staff. Proposed policies and procedures and amendments may be brought before the voting members of the medical staff by petition signed by a simple majority of voting members. Before any such proposed policy and procedure or amendment is voted on by the voting members of the medical staff, it shall first be submitted to the Medical Executive Committee at the next meeting of the Medical Executive

Committee for review and comment. The Medical Executive Committee's recommendation with respect to the proposed policy and procedure or amendment may accompany the ballot, which may be written or electronic.

C. In the event of a conflict between the Medical Executive Committee and the medical staff regarding the adoption of any policy and procedure, or any amendment thereto, the matter may be submitted to the conflict management process in Article Eleven.

D. Following approval by the Medical Executive Committee or the voting members of the medical staff as described above, a proposed policy and procedure, or amendment thereto, shall be forwarded to the Board. The Medical Executive Committee may forward to the Board its comments on any policy and procedure or amendment approved by the voting members of the medical staff. Policies and procedures, and amendments thereto shall become effective when approved by the Board.

2. Notification Regarding Policies and Procedures

Notification of adoption of policies and procedures and amendments thereto shall be distributed to the medical staff by posting on the medical staff pages of the hospital website, publication in the medical staff newsletter or other means of notification, including but not limited to, mail, facsimile transmission, or e-mail.

ARTICLE ELEVEN

XI. CONFLICT MANAGEMENT PROCESS

A. In the event of a conflict between the Medical Executive Committee and the medical staff regarding the adoption or amendment of any rule and regulation or policy and procedure, upon a petition signed by a simple majority of voting members of the medical staff, the matter shall be submitted to the following conflict resolution process.

1. A Conflict Resolution Committee shall be formed consisting of up to five (5) representatives of the voting members of the medical staff designated by the voting members of the medical staff submitting the petition, and an equal number of representatives of the Medical Executive Committee appointed by the Chief of Staff or designee. The President/CEO or designee shall be an ex-officio non-voting member of the Conflict Resolution Committee.

2. The members of the Conflict Resolution Committee shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties in a manner consistent with protecting safety and quality.

3. Any recommendation which is approved by a majority of the representatives of the voting members of the medical staff and a majority of the representatives of the Medical Executive Committee shall be submitted to the Board for consideration and is subject to final approval by the Board. If agreement cannot be reached by a majority of the representatives of the voting members of the medical staff and a majority of the representatives of the Medical Executive Committee, the members of the Conflict Resolution Committee shall report to the Board regarding the unresolved differences for consideration by the Board in making its final decisions regarding the matter in dispute.

4. If deemed appropriate by the Chief of Staff and the President/CEO, an outside mediator or facilitator may be engaged to assist with the resolution of any disputed issue.

B. Nothing in the foregoing is intended to prevent medical staff members from communicating with the Board on a rule, regulation, or policy, or amendment thereto, adopted by the voting members of the medical staff or the Medical Executive Committee in accordance with any mechanism established by the Board for such communications.

ARTICLE TWELVE

XII. ADOPTION AND AMENDMENT OF BYLAWS

A. STAFF RESPONSIBILITY AND AUTHORITY

1. The Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Board any Medical Staff Bylaws and Amendments thereto which shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner.

2. Neither body may unilaterally amend the Bylaws or Rules and Regulations.

B. BYLAW AND RULES COMMITTEE PROCEDURE

1. All proposed amendments of these Bylaws, whether initiated by the Medical Staff Executive Committee, another committee, or by a voting member of the Medical Staff, shall, as a matter of procedure, be referred to the Bylaws and Rules Committee.

2. The Bylaws and Rules Committee shall meet and formulate the changes and, after recommendation(s) has been determined, it shall make a written report to the Medical Staff Executive Committee.

C. MEDICAL STAFF EXECUTIVE COMMITTEE PROCEDURE

1. All proposed amendments of these Bylaws whether initiated by the Medical Executive Committee, another committee, or by a voting member of the medical staff shall, as a matter of procedure, be referred to the Medical Staff Executive Committee. All proposed amendments approved by the Medical Executive Committee shall be submitted to the voting members of the medical staff for approval in accordance with the procedure in Section 2, Procedure for Mail Vote below. If the Medical Executive Committee does not approve a proposed amendment that has been referred to it, then it shall so notify the committee or individual that proposed the amendment.

D. PETITION

1. If the Medical Executive Committee does not approve a proposed amendment that has been referred to it, any voting member of the medical staff may cause such proposed amendment to be presented to the voting members of the medical staff for a vote by obtaining the signatures of a simple majority of voting members of the medical staff on a petition and submitting the petition to the Medical Executive Committee. Upon receipt of such a petition, the Medical Executive Committee shall cause the proposed amendment to be presented to the voting members of the medical staff for vote in accordance with the procedure in Section 2, Procedure for Vote below.

E. STAFF PROCEDURE

1. Procedure for Mail Vote

    a. Proposed amendments may be submitted to the voting members of the medical staff for vote by written or electronic ballot according to such procedures as are approved by the Medical Executive Committee. The Medical Executive Committee's recommendation with respect to the proposed amendment may accompany the ballot. Proposed amendments may also be voted on at any meeting of the medical staff, provided that the proposed amendment has been distributed to the voting members of the medical staff at least fourteen (14) days in advance of such meeting by mail, facsimile transmission, email, or posting on the medical staff pages of the hospital website.

    b. To be adopted, an amendment shall require a majority vote of the members voting. Ballots that are not returned shall be counted as votes in favor of the Medical Staff Executive Committee's recommendation.

F. TECHNICAL AMENDMENTS

1. The Medical Staff Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in the Committee's judgment, technical or legal modifications or clarifications; reorganization or renumbering; or amendments needed because of punctuation, spelling, or other errors of grammar or expression.

G. BOARD APPROVAL

1. Amendments shall be effective when approved by the affirmative vote of a majority of the Board.

2. In the event the Staff shall fail to exercise its responsibility and authority as required in Article XI, Section A, and after notice to the Staff including a thirty (30) day period of time for response, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws. In such event, Staff recommendations and views shall be carefully considered by the Board in its deliberations and in its action, which shall be pursuant to this section.

3. Notification of amendments shall be distributed to all members of the Medical Staff by publication in the Medical Staff newsletter or other means of notification including but not limited to mail, facsimile transmission or e-mail.

H. REGULAR REVIEW

The Medical Staff Bylaws shall be reviewed at least every five (5) by the Bylaws and Rules Committee.

ARTICLE THIRTEEN

XIII. FAIR HEARING PLAN

A. RIGHT TO HEARING AND APPELLATE REVIEW

1. The purpose of this fair hearing plan is to provide a mechanism through which an appeal and a fair hearing might be provided to all practitioners as defined in these Bylaws. Article XII is intended to comply with the Health Care Quality Improvement Act of 1986, the Medicare/Medicaid "Conditions of Participation" and Florida Statutes 395.0191 and 395.0193.

2. Article XII shall apply to and be available for all practitioners adversely affected by actions taken by any of the committees described in this Article and/or the Hospital Board of Directors and shall control over all other Articles in the Bylaws. Any doubts concerning the right of a practitioner to avail himself or herself of the provisions of this Article XII shall be resolved in favor of the practitioner.

3. The Medical Staff Executive Committee, as described in these Bylaws, shall be considered the initial review committee and shall be responsible for the early review of matters involving peer review and quality assurance as well as early review of matters involving credentialing of practitioners not yet admitted to the Hospital Medical Staff. In dealing with practitioners who seek admission to the Hospital Medical Staff, all material portions of Article V of these Bylaws shall apply.

4. No member of the Medical Staff Executive Committee shall be ineligible to serve as a member of the initial review committee because the member has actively participated in the investigation of the practitioner or because the member is in the same field of medicine as the practitioner.

B. ADVERSE RECOMMENDATION BY MEDICAL STAFF EXECUTIVE COMMITTEE

1. When any practitioner receives a notice of a recommendation of the Medical Staff Executive Committee that, if ratified by the Board of Directors, will adversely affect the practitioner's

appointment to or status as a member of the Medical Staff or the exercise of clinical privileges, the practitioner shall be entitled, upon request, to a hearing before an Ad Hoc Committee established for that purpose.

2. The Ad Hoc Committee shall be made up of at least three (3) persons appointed by the Medical Staff President. The Ad Hoc Committee shall be composed of members of the Medical Staff who have not actively participated in the consideration of the matter involved at any previous level, or of physicians or laymen not connected with the hospital. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving on the Ad Hoc Committee. No person who is in direct economic competition with the person requesting the hearing shall be appointed to the Ad Hoc Committee.

3. The following recommendations will be considered to adversely affect the practitioner's appointment to or status as a member of the Medical Staff or exercise of clinical privileges:

   a. Denial of initial appointment;

   b. Denial of reappointment;

   c. Revocation of appointment;

   d. Denial of requested initial clinical privileges;
   e. Denial of requested increased clinical privileges;

   f. Reduction of clinical privileges;

   g. Revocation of clinical privileges;

   h. Imposition of a mandatory concurring consultation requirement;

   i. Suspension of clinical privileges;

   j. Denial of request for reinstatement following Leave of Absence.

4. No action, recommendation, or matter other than those enumerated in this section shall constitute grounds for hearing and appeal.

C. NOTICE BY MEDICAL STAFF EXECUTIVE COMMITTEE OF ADVERSE RECOMMENDATION

1. The President of the Medical Staff or the chairperson of the Medical Staff Executive Committee shall be responsible for giving prompt written notice of an adverse recommendation or decision by the Medical Staff Executive Committee and the reasons for such recommendation or decision to any affected practitioner by personal delivery or by certified mail, return receipt requested, within seven (7) days after the Medical Staff Executive Committee makes such decision. The notice shall include a statement of the action taken or proposed to be taken, the reasons therefore, a statement of the practitioner's right to request a hearing, and the time limit in which the hearing must be requested. The written notice shall either include copies of Article XII of these Bylaws or set out in writing a brief description of the practitioner's rights in the hearing.

2. From the date the practitioner receives the notice of recommendation of the Medical Staff Executive Committee, he or she shall have thirty (30) days to request such hearing and failure to do so within the thirty (30) day period shall be deemed a waiver of the practitioner's right to such hearing and to any other hearing to which the practitioner might have been entitled. If the

practitioner fails to request the hearing within the thirty (30) day period, the matter shall be forwarded directly to the Board of Directors and the decision by the Board of Directors shall become final.

D. INITIAL ADVERSE ACTION BY THE BOARD OF DIRECTORS

When any practitioner receives notice of a decision by the Board of Directors taken either contrary to a favorable recommendation by the Medical Staff Executive Committee where no right to a hearing existed or on the Board's own initiative without benefit of a prior recommendation by the Medical Staff Executive Committee under circumstances where no right to a hearing existed, and such decision by the Board of Directors will adversely affect the practitioner's appointment to or status as a member of the Medical Staff or the exercise of clinical privileges as defined in Article XII, Section B, Paragraph 3 above, the practitioner shall be entitled, upon request, to a hearing before an Ad Hoc Committee in the same manner as set out in Article XII, Section C.

E. NOTICE BY BOARD OF DIRECTORS OF ADVERSE ACTION

1. The President of the Board or the Executive Director/CEO of the Hospital or his or her designee shall be responsible for giving prompt written notice of an adverse recommendation or decision by the Board and the reasons for such decision to any affected practitioner by personal delivery or by certified mail, return receipt requested, within seven (7) days after the Board makes such decision. The notice shall include a statement of the action taken or proposed to be taken, the reasons therefore and a statement of the practitioner's right to request a hearing and the time limit in which the hearing must be requested. The written notice shall include either copies of Article XII of these Bylaws or set out in writing a brief description of the practitioner's rights in the hearing.

2. From the date the practitioner receives the notice of recommendation of the Board of Directors pursuant to this Article XII, Section E, he or she shall have thirty (30) days to request such hearing and failure to do so within the thirty (30) day period shall be deemed a waiver of the practitioner's right to such hearing, and to any other hearing to which the practitioner might have been entitled, and decision of the Board of Directors shall become final.

F. NOTICE OF HEARING

1. If a hearing is requested following an adverse recommendation by the Medical Staff Executive Committee as provided by Article XII, Section C, the President of the Medical Staff or the chairperson of the Medical Staff Executive Committee shall be responsible for giving written notice of the date, time and place of the hearing to the person who requested the hearing.

2. If a hearing is requested following an adverse decision by the Board as provided by Article XII, Section E, the Chairperson of the Board or the Executive Director/CEO of the hospital, or designee, shall be responsible for giving written notice of the date, time and place of the hearing to the person who requested the hearing.

3. Written notice of the date, time, and place of the hearing shall be provided to the person who requested the hearing at least thirty (30) days in advance of the hearing.

4. The written notice of hearing shall include the names and addresses of the witnesses, so far as are reasonably known, who are expected to testify at the hearing on behalf of the Medical Staff Executive Committee or the Board, as applicable. The names and addresses of additional witnesses shall be provided as soon as procured.

5. The written notice of hearing shall include a list of the charts, if any, in question.

6. The Medical Staff Executive Committee or the Board, as applicable, may request the person who requested the hearing to provide a list of witnesses who are expected to testify at the hearing on behalf of that person. The person requesting the hearing shall provide a written list of names and addresses of the witnesses, so far as are then reasonably known, within ten (10) days of such request, and shall provide the names and addresses of additional witnesses as soon as procured.

G. HEARING BEFORE AD HOC COMMITTEE

1. If a hearing is requested, the hearing shall be conducted in accordance with the procedures set out in Article XII, Section E.

2. After the completion of a hearing before the Ad Hoc Committee, the chairperson of the Ad Hoc Committee shall be responsible for giving written notice to the practitioner, the Medical Staff Executive Committee and the Board of Directors of the recommendations of the Ad Hoc Committee and the reasons for such recommendation within seven (7) days from the conclusion of the hearing. The notice shall include:

   a. a statement of the action recommended;

   b. the reasons for such recommendation;

   c. a statement to the practitioner that whether the recommendation is favorable or adverse; the Ad Hoc Committee is an advisory committee only and the Board of Directors will make the final decision; that if the recommendation is adverse to the practitioner, the practitioner has thirty (30) days from receipt of the notice to request appellate review by the Board of Directors and his or her failure to do so within the thirty (30) day period shall be deemed a waiver of the practitioner's right to such appellate review; and if the practitioner fails to request the appellate review, the matter will be decided by the Board of Directors at its next meeting following the expiration of the thirty (30) day period without the presence of the practitioner.

H. FINAL ACTION BY THE BOARD OF DIRECTORS

1. If the practitioner or Medical Staff Executive Committee requests an appellate review by the Board within the time limits allowed, the appeal shall be conducted in accordance with the procedures set out in Article XII, Section P, following which the Board will take final action.

2. If no appellate review is requested within the time limits allowed, the practitioner and Medical Staff Executive Committee will be deemed to have waived the right to appeal, and the Board may take final action in the matter at its next meeting. At any time, the Board may refer a matter for further review and recommendation.

3. The Executive Director/CEO will authorize the designated administrative representative to notify the National Practitioner Data Bank and any other reporting entities, if required, after all appeals have been exhausted.

I. SERVICE ON AD HOC COMMITTEE

Service on the Ad Hoc Committee shall be considered sufficient if it is personally delivered to the Executive Director/CEO of the Hospital or is sent by certified mail, return receipt requested, to the attention of the Executive Director/CEO of the Hospital.

J. SERVICE ON MEDICAL STAFF EXECUTIVE COMMITTEE

Service on the Medical Staff Executive Committee shall be considered sufficient if it is personally delivered to the President of the Medical Staff or is sent by certified mail, return receipt requested, to the attention of the President of the Medical Staff.

K. SERVICE ON BOARD OF DIRECTORS

Service on the Board of Directors shall be considered sufficient if it is personally delivered to the Executive Director/CEO of the Hospital or the President of the Board of Directors; or is sent by certified mail, return receipt requested, to the attention of the Executive Director/CEO of the Hospital.

L. SERVICE ON PRACTITIONER

Service on a practitioner shall be considered sufficient if it is personally delivered to the practitioner or is sent by certified mail, return receipt requested, to the last mailing address the practitioner furnished to the Hospital.

M. REQUIREMENTS FOR COMPLYING WITH THE VARIOUS TIME PERIODS

The requirements for complying with the various time periods are as follows:

1. Request for hearing by practitioner from adverse recommendation of Medical Staff Executive Committee – thirty (30) days;

2. Request for hearing by practitioner from decision of Board of Directors contrary to recommendation of the Medical Staff Executive Committee - thirty (30) days;

3. Appeal by practitioner or Medical Staff Executive Committee from any recommendation of the Ad Hoc Committee – thirty (30) days;

4. Notice to practitioner by Medical Staff Executive Committee of committee's recommendation – seven (7) days;

5. Notice to practitioner by Ad Hoc Committee of recommendation following hearing – seven (7) days;

6. Notice to practitioner by Board of Directors of any decision affecting the practitioner, either favorably or adversely within seven (7) days;

7. Maximum days for any committee to schedule a hearing after receipt of an appeal by a practitioner. The hearing should be scheduled as soon as practicable following receipt of the request, keeping in mind that the practitioner must be given at least thirty (30) days notice in advance of hearing. If the hearing cannot take place within ninety (90) days following receipt of the hearing request, the practitioner shall be advised in writing of the reason for delay.

8. The above time periods are calendar days. If the last day of the time period falls on a weekend or holiday, the time period shall be extended to the next working day.

9. Notices of Adverse Recommendations, Requests for Hearings, Notices of Hearings and all other matters that are controlled by time periods shall be considered properly complied with if the notice or request is personally delivered to the proper person as set out in Article XII, Section I – Section L, by 5:00pm on the last day of such time period, or is sent by certified mail, return receipt requested, and postmarked no later than 12:00 Midnight on the last day of such time period. If the last day of a time period falls on a weekend or a legal holiday, the last day of

such time period is extended to the next working day.

N. EXCEPTIONS TO HEARING AND APPEAL PROCESS

1. If a practitioner has been summarily suspended or has had his or her privileges materially affected by a summary decision, and the practitioner is not satisfied with the results of the review by the Medical Staff Executive Committee under Article V, Section B, the practitioner shall have the right to request an immediate hearing before an Ad Hoc Committee and every reasonable effort shall be made to schedule the hearing as soon as possible, taking into consideration the requirements of a quorum and the gathering of evidence to present to the committee.

2. In no event shall a hearing be held later than ten (10) days after the formal request of the practitioner is received unless the time period is extended at the request of the practitioner or a delay is caused by the practitioner.

O. HEARING PROCEDURE

1. Personal Presence

   The personal presence of a practitioner who requested the hearing shall be required. A practitioner who fails without good cause to appear and participate in such hearing shall be deemed to have waived his or her rights in the same manner and with the same consequences as provided for in Article XII, Section C and Section D.

2. Presiding Hearing Officer

   a. The following persons shall be the presiding officers of the following Hearing Committees:

Committee	Presiding Hearing Officer
Medical Staff Executive Committee	Chairperson of Committee
Ad Hoc Committee	Committee member designated by the President of the Medical Staff, Board of Directors, Chairperson of the Board

   b. Any presiding officer of any of the above committees shall have the right to appoint any other committee member as the Presiding Hearing Officer. No advance notice of such appointment shall be required. The Presiding Hearing Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant testimony and documentary evidence. He or she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

3. Representation

   a. Except for the "Interviews" set out in Article V, Section A – Section C of these Bylaws, the practitioner who requested the hearing shall be entitled to be accompanied and advised at any hearing by any or all of the following: (1) an attorney or attorneys, (2) members of the Medical Staff in good standing, or (3) members of his or her local professional society. The practitioner shall inform the President of the Medical Staff (in the case of a hearing on a recommendation by the Medical Staff Executive Committee) or the Chairperson of the Board (in the case of a hearing on a decision by the Board) of his or her choice in advance

of the hearing, upon request. The practitioner's presentation shall be made by the practitioner or the person of his or her choosing.

b. The President of the Medical Staff (in the case of a hearing on a recommendation by the Medical Staff Executive Committee) or the Chairperson of the Board (in the case of a hearing on a decision by the Board) shall have the right to appoint any person to represent the Medical Staff Executive Committee or Board at such Hearing to present evidence in support of the Committee's or Board's position and to examine witnesses. If the person requesting the hearing uses an attorney to present his or her position in the hearing, the other side may do likewise.

4. Representation at Interviews

a. As stated in Article V, Section A – Section C of these Bylaws, the intent of the "Interview" is to resolve problems or concerns affecting a practitioner in an informal manner without the necessity of subsequently having to file formal reports to any governmental agency.

b. If at all possible, the committee involved shall not have attorneys or other non-members present; however, there may be times when expert testimony or advice is needed or investigative reports are needed. In such cases, the committee shall have the right to have the necessary additional persons present. If the committee decides to have persons present at the interview in addition to the committee members, the chairperson of the committee shall notify the practitioner at least two (2) days before the interview. Upon a showing of special circumstances by the practitioner, the committee chairperson may allow the practitioner to have other persons of his or her choosing present at the interview.

5. Service on Hearing Committee

A Staff or Board member shall not be disqualified from serving on an Ad Hoc Committee merely because he or she has information concerning the facts of the case. All members of a Hearing Committee shall be required to consider and decide each case in good faith without fraud.

6. Immunity of Peer Review

The Board of Directors, in conjunction with the Medical Staff and any committees, departments and hospital personnel thereof, in order to conduct professional peer review activity, hereby constitute themselves as peer review committees as defined by Florida law and the Health Care Quality Improvement Act of 1986.

7. Rights of Parties

During a hearing, each of the parties shall have the right to:

a. Call and examine witnesses;

b. Introduce exhibits;

c. Cross-examine any witness on any matter relevant to the issues;

d. Impeach any witness;

e. Rebut any evidence;

f. Have a record of the hearing made by use of a court reporter or electronic recording unit. The party requesting the hearing is entitled to a copy of the record of the hearing upon payment of the reasonable charges for the preparation thereof.

g. If the practitioner who requested the hearing does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

h. Each party shall have the right to submit a memorandum or other written statement in support of its position, and the Ad Hoc Committee may request such a memorandum to be filed, following the close of the hearing.

8. Procedure and Evidence

a. The hearing shall not be conducted strictly according to rules of law relating to the examination of or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law.

b. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The presiding officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him and entitled to notarize documents.

9. Burden of Proof

a. The Medical Staff Executive Committee or the Board, depending on whose recommendation prompted the hearing, shall first come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the person who requested the hearing to come forward with evidence in support of his or her position.

b. After all the evidence has been submitted by both sides, the Ad Hoc Committee shall recommend against the person who requested the hearing unless it finds that said person has proved that the recommendation of the Medical Staff Executive Committee or the Board was unreasonable, not sustained by evidence, or otherwise unfounded.

10. Postponement

Request for postponement of a hearing shall be granted by the Hearing Committee only upon a showing of good cause.

11. Recesses and Adjournment

a. The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

b. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of its deliberations, the hearing shall be declared adjourned.

P. APPELLATE REVIEW PROCEDURE

1. Time for Appeal

   a. Within thirty (30) days after the affected practitioner is notified of either (a) a recommendation adverse to him or her made by the Ad Hoc Committee or (b) an action by the Board which reverses a favorable recommendation of the Ad Hoc Committee, the applicant or member may request an appellate review by the Board.

   b. Should the recommendation of the Ad Hoc Committee or action by the Board be contra to the recommendation of the Medical Staff Executive Committee, such committee may request an appellate review by the Board within thirty (30) days after notification. Said written request shall be delivered to the President either in person, or by certified or registered mail. The written request for appellate review shall include a brief statement as to the reasons for appeal.

   c. If appellate review is not requested within thirty (30) days as provided above, both sides shall be deemed to have accepted the recommendation involved and it shall thereupon become final and shall be effective upon final Board approval.

2. Grounds for Appeal

   The only grounds for appellate review shall be:

   a. Substantial failure to comply with the Hospital or Medical Staff Bylaws in the conduct of hearings and decisions upon hearings so as to deny due process or a fair hearing; or
   b. Action taken arbitrarily, capriciously or with prejudice; or

   c. The recommendation of the Ad Hoc Committee or the Board action was not supported by the evidence.

3. Time, Place, and Notice

   a. The Chairperson of the Board, or designee, shall schedule and arrange for the appellate review and shall cause the practitioner to be given notice of the time, place, and date of the appellate review. The date of the appellate review shall be not less than thirty (30) days, nor more than ninety (90) days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from a member who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than thirty (30) days from the date of receipt of the request for appellate review.

   b. The time for appellate review may be extended by the Chairperson of the Board or designee for good cause.

4. Nature of Appellate Review

   a. The Chairperson of the Board, or designee, shall appoint a Review Panel composed of not less than three (3) persons, either Board members, reputable persons outside the hospital, or a combination of the two (2), none of whom are in direct economic competition with the practitioner, to consider all records providing the basis upon which the recommendation was made.

   b. Each party shall have the right to present a written statement in support of the position on appeal. In its sole discretion, the Review Panel may allow each party or its representative

to appear personally and make oral argument. The Review Panel may, in its sole discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the hearing.

c. The Review Panel shall recommend final action to the Board. The Review Panel's written recommendation shall be served no later than twenty (20) days after the conclusion of the proceedings before the Review Panel.

5. Final Decision of the Board

a. At its next meeting after receipt of the recommendation of the Review Panel, the Board shall render a decision in writing. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, may refer the matter for further review and recommendation. The Board's decision shall include a statement of the basis for the decision. Copies thereof shall be delivered to the practitioner and to the Medical Staff Executive Committee in person, or by certified or registered mail.

b. Except where the matter is referred for further review and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review.

c. If the matter is referred for further review and recommendation, such recommendations shall be promptly made to the Board in accordance with the instructions given by the Board no later than the next meeting of the Board. Thereafter the Board shall render a final decision, including a statement of the basis for the decision, and shall deliver copies thereof to the practitioner and the Medical Staff Executive Committee in person or be sent certified or registered mail.

6. Right to One Appeal Only

No applicant or member shall be entitled to more than one (1) appellate review on any single matter which may be the subject of an appeal, without regard to whether such subject is the result of action by the Medical Staff Executive Committee, or the Board, or recommendation of an Ad Hoc Committee, or a combination of acts of such bodies. However, nothing herein shall restrict the right of an applicant to reapply for membership on the Medical Staff or the right of a member of the Medical Staff to apply for an increase in clinical privileges after the expiration of two (2) years from the date of such denial of application unless the Board provides otherwise in the formal written denial.

ARTICLE FOURTEEN

XIV. RULES & REGULATIONS OF THE MEDICAL STAFF

A. ADMISSION AND DISCHARGE OF PATIENTS

1. Physicians requesting admission for their patients shall provide the hospital with a provisional diagnosis and will give such other information as may be required to enable the hospital to take such action as is necessary to protect patients already in the hospital from patients who are or may become a source of danger from any cause whatever.

2. Emergency patients may be admitted without data required in Number 1, but the attending physician will be expected to furnish such data within twenty-four (24) hours after admission of the patient.

3. All patients shall be attended by members of the Active and Courtesy Staff. Patients with personal physicians shall be attended by their personal physician and all unassigned patients shall be assigned to the service concerned in the treatment of the disease which necessitated the admission. No physician shall refuse emergency treatment of a patient because of lack of compensation.

4. All patients assigned to and attended by the on-call physician shall be provided follow-up care by that same physician for the emergency medical condition that caused their emergency department visit and/or hospital admission.

5. Patients shall not be discharged from the hospital until the following has occurred:

a. A provisional or final discharge diagnosis has been written on the chart by the physician or by the nurse on verbal order from the physician.

b. A referral is made with the patient's personal or assigned physician for follow-up care.

B. GENERAL STANDARDS OF PATIENT CARE

1. A hospital formulary will be prepared and kept up to date by the hospital pharmacist with the approval and under the direction of the pharmacy and therapeutics function of the Medical Staff. Acceptance of these Bylaws, Rules and Regulations also specifically implies acceptance of this formulary and its use.

2. Medications and prescriptions brought into the hospital by patients must have written orders by the attending physician, surgeon, podiatrist or dentist, stipulating the dosage indicating his or her assumption of full responsibility for such medication, which will then be given at this direction by hospital personnel. Patients without such orders will not be permitted to use their own medications while a patient in this hospital.

3. All surgical specimens, other than approved exceptions shall be sent to the hospital pathologist who shall make such examinations as he or she shall consider necessary to arrive at a pathological diagnosis.

4. Each patient in the hospital shall be seen at least once daily by his or her attending physician or some other Medical Staff member designated by the attending physician.

5. Each member of the Medical Staff not readily available shall designate an alternate. In case of failure to name such alternate, the President of the Medical Staff or, in his or her absence or unavailability, the Executive Director/CEO of the hospital or the Executive Director/CEO's designee shall have the authority to call any member of the Medical Staff should he or she consider it necessary. Each member of the Medical Staff, except the Honorary Medical Staff, shall keep the Executive Director/CEO of the hospital informed of his or her correct address and telephone number.

6. Consultations

   a. Consultant: A consultant must be well qualified to give an opinion in the field in which his or her opinion is sought. He or she shall be a member in good standing of the SLH Medical Staff.

   b. The consultant shall make and sign a record of his or her findings and recommendations. (Description of Consultation" is included in Article XIII, Section C, Paragraph 4)

7. Every member of the Medical Staff shall be actively interested in securing autopsies, whenever possible.

C. MEDICAL RECORDS

1. Procedures/Medical Records

   a. The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current and contain sufficient information to identify the patient, to support the diagnosis and treatment and to document the results accurately.

b. All clinical entries in the patient's medical record shall be accurately and legibly dated, contain no prohibited abbreviations, and be signed by the physician initiating the order or report. All errors noted in the medical record shall be single-lined out, noted as error, and legibly dated and initialed.

c. A medical record shall be considered complete when the required contents are assembled and signed following discharge of the patient. Failure of the Medical Staff member to complete medical records within thirty (30) days of discharge and after written warning of such delinquency shall be grounds for automatically relinquishing a staff member's elective admitting and surgical privileges. The Medical Staff member will be reported to the respective Department Chief, Chief of Staff and CEO. Automatic loss of all hospital privileges will result for any staff member whose suspension continues in effect in excess of fourteen (14) days following the onset of suspension of admitting and surgery privileges for failure to complete medical records. Only upon completion of all medical records and payment of the application fee may the individual then reapply through the Credentials Committee as new applicant for medical staff privileges.

d. A Medical Staff member who is ill or on vacation or leave of absence shall not be penalized for having incomplete medical records, providing he or she notifies the Manager of the Health Information Management Department. The Medical Staff member will be given three (3) days from the time he or she again becomes available to satisfy the 30-day requirement. Extension shall not apply to absences of less than three (3) days, or in instances where records are delinquent prior to departure.

e. Medical records shall not be filed until complete, except on order of Administration.

2. History and Physical Examination

a. Requirements

(1) A medical history and physical examination must be completed for each patient no more than thirty (30) days prior to, or within twenty-four (24) hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.
(2) Only those physician members of the Medical Staff, who have been granted privileges by the Medical Staff in accordance with State law, may conduct and update medical histories and physical examinations. Privileges to conduct and update medical histories and physical examinations are granted to:
- Physicians
- Oral Surgeons, for those patients admitted solely for oral and maxillofacial surgery
- Dentists only for that part of the history and physical examination related to dentistry
- Podiatrists only for that part of the history and physical examination related to podiatry.
- Other qualified individuals who are not licensed independent practitioners may be allowed pursuant to their scope of practice to perform part or all of patients' medical histories and physical examinations under the supervision of, or through appropriate delegation by, a physician who is a medical staff member with clinical privileges and who is accountable for the patients' medical histories and physical examinations; these medical histories and physical

examinations must be validated and countersigned by a licensed independent practitioner with appropriate privileges.

(3) In-Patient

(a) A history and physical examination must be performed within twenty-four (24) hours of in-patient admission and must contain the elements and criteria established by the Medical Staff and identified within these Bylaws.

(b) If using a history and physical examination that was performed no more than thirty (30) days prior to in-patient admission/readmission, it must be updated to include all additions to the history and any changes in physical findings. This update examination must be completed and documented in the patient's medical record within twenty-four (24) hours after admission and may be recorded in the progress notes of the patient's record.

(c) A history and physical examination performed over thirty (30) days prior to in-patient admission/readmission is not acceptable and a new history and physical examination must be completed.

(d) A note or interval history and physical examination may be used if a patient is readmitted within thirty (30) days for the same or related problem in accordance with 2)b above, providing the original information is readily available, such as in a unit record.

(e) The history and physical examination, the results of any indicated diagnostic tests, as well as a provisional diagnosis must be recorded before the operative or other procedures, with the exception of emergencies, by the physician responsible for the patient prior to surgery or any potentially hazardous diagnostic procedure.

(f) In addition to the prenatal record on obstetrical patients, a history and physical must be performed on the patient (and documented) within 30 days prior to any surgery and prior to being transferred to the postpartum unit.

(g) A pre-anesthesia evaluation by a qualified individual must be performed and in the medical record prior to surgery.

(4) Out-Patient Surgery

(a) A history and physical examination must be performed prior to admission for out-patient surgery and must contain the elements and criteria established by the Medical Staff and identified within these Bylaws.

(b) If using a history and physical examination that was performed no more than thirty (30) days prior to out-patient surgery, it must be updated to include all additions to the history and any changes in physical findings. This update may be recorded on the original history and physical examination.

(c) A history and physical examination performed over thirty (30) days prior to admission for out-patient surgery is not acceptable and a new history and physical examination must be completed.

(d) The history and physical examination, the results of any indicated diagnostic tests, as well as a provisional diagnosis must be recorded before the operative or other procedures, with the exception of emergencies, by the physician responsible for the patient prior to surgery or any potentially hazardous diagnostic procedure.

(e) A pre-anesthesia evaluation by a qualified individual must be performed and in the medical record prior to surgery.

(5) Ambulatory Treatment/Procedure

(a) For the purpose of this section, ambulatory treatment/procedure means non-inpatient, non-surgical services such as pain injections, chemotherapy or blood transfusions, which are performed in a series.

(b) Initial Treatment/Procedure

i. A history and physical examination must be performed prior to admission for ambulatory treatment/procedure and must contain the elements and criteria established by the Medical Staff and identified within these Bylaws.

ii. If using a history and physical examination that was performed no more than thirty (30) days prior to admission for ambulatory treatment/procedure, it must be updated immediately prior to the treatment/procedure and must include all additions to the history and any changes in physical findings. This update may be recorded on the original history and physical examination.

iii. A history and physical examination performed over thirty (30) days prior to admission for ambulatory procedure/treatment is not acceptable and a new history and physical examination must be completed.

(c) Subsequent Treatment/Procedure

i. For the purpose of this section, subsequent treatment/procedure refers to subsequent treatment for the same condition or as part of the same series.
ii. An update must be performed immediately prior to admission for ambulatory procedure/treatment and must include the following:
    01. Focal examination of area/system being treated or upon which procedure is being done;
    02. Documentation of relevant medical/surgical history since last treatment/procedure.
iii. This update may be recorded in the progress notes.
iv. A history and physical examination performed over thirty (30) days prior to admission for subsequent treatment/procedure is not acceptable and a new history and physical examination must be completed.

b. Elements

(1) The medical history should include the chief complaint, details of the present illness (including, when appropriate, assessment of the patient's emotional, behavioral and social status), relevant past, social and family histories, and an inventory of body systems and current medications.

(2) The physical examination shall reflect a comprehensive current physical assessment.

(3) The history and physical must also include a statement of the conclusions or impressions drawn from the history and physical, and a statement of the course of action planned for the patient while in the hospital.

c. Podiatric Care

(1) Patients admitted for podiatric care must have a history and physical and evaluation of overall medical risk by a physician member of the Medical Staff.

(2) The podiatrist is responsible for that part of the history and physical related to podiatry.

c. Newborn

Newborn records must document a complete physical examination on birth and again prior to discharge; provided that, if the infant is discharged within thirty-six (36) hours of birth, with the diagnosis of "Term Male (Female) Delivery" (ICD V30-39) and with no other diagnosis than newborn physiologic jaundice (ICD 774.6), the birth and discharge examinations may be one and the same.

3. Diagnostic and Therapeutic Orders

a. Orders must be written clearly, legibly, and completely.

b. Verbal/Telephone Orders

(1) The use of verbal/telephone orders is discouraged. If verbal orders are used, they should be used only infrequently and should be limited to those situations in which it is impossible or impractical for the ordering practitioner to write the order either manually or electronically. Verbal/telephone orders are not to be used solely for the convenience of the ordering practitioner.

(2) All verbal orders shall be read back to the person dictating the order to verify accuracy.

All verbal/telephone orders shall be signed by the registered nurse or other authorized personnel to whom dictated with the name of the physician by his or her name.

Categories of persons authorized to accept verbal/telephone orders and write or electronically generate those orders through South Lake Hospital's automated order entry system are:

(a) Registered nurses, advanced registered nurse practitioners, certified registered nurse anesthetists and graduate nurses;

(b) Physician assistants;

(c) Respiratory therapists;

(d) Radiology technicians;

(e) Laboratory technicians;

(f) Registered rehabilitation therapist, e.g. physical therapists, speech therapists and occupational health therapists and audiologists

(g) Licensed practical nurses;

(h) Orthopedic technicians

(i) Registered pharmacists and registered pharmacy interns;

(j) Registered dieticians

(k) Case managers as orders pertain to discharge planning and

(l) Licensed clinical social workers, licensed mental health counselors and licensed marriage/family therapists.

(3) All verbal/telephone orders must be authenticated by the physician, dentist, or podiatrist initiating the order (or by a group member or covering physician who is authorized to sign for that individual). Verbal/telephone orders should be authenticated at the next opportunity (i.e., the next time the patient is assessed and/or information is documented in the medical record) and must be authenticated within 24 hours for Do Not Resuscitate and Restraint orders and within 48 hours for all other orders.

(4) STANDING ORDERS

Standing orders/order sets shall not, however, replace or cancel those written for the specific patient. Standing order/ sets may be used by individual physicians, podiatrists or dentists after approval by the Executive Committee of the Medical Staff. These orders shall be followed insofar as proper treatment of the patient will allow, and when the attending physician does not write specific orders, they shall constitute the orders for treatment. Standing orders shall not, however, replace or cancel those written for the specific patient.

c. STOP-ORDERS

Unless otherwise ordered by the physician, podiatrist or dentist, all orders, except operative/procedural orders, shall be automatically cancelled when a patient undergoes surgery or obstetrical delivery. Each individual order must be rewritten post-operatively. “Resume pre-op orders” or similar notation is not sufficient.

d. RESTRAINT ORDERS

A physician’s order is required for medical/surgical restraint and written or verbal orders for initial or continued restraint use are time limited.

e. WRITTEN ORDERS

(1) Written orders must be legible.

(2) Print must be large enough to reproduce easily by fax or copy.

(3) Abbreviations may not be used for medication names. All other abbreviations used

must conform to the approved abbreviation resource.

(4) Orders must be written with pens/devices capable of transferring legibly through multiple copies. Felt tip pens may not be used.

(5) Changes to existing orders must be made by way of new orders. Existing orders may not be corrected or scratched over.

(6) All admitting orders must include patient allergies.

(7) All physician, podiatrist or dentist orders must be accompanied by the assigned four (4) digit dictation number in addition to the signature of the prescriber.

(8) All orders must be timed and dated.

(9) Direct admissions must be accompanied by physician orders.

(10) Patients undergoing a change in level of care must have current orders reviewed and signed by physician.

(11) The patient's full name must be documented on the order sheet prior to order being written.

(12) Physician must attempt to use South Lake Hospital order sheets or office letterhead for direct admissions.

(13) Medication Orders

(a) Abbreviations may not be used for medication names. All other abbreviations must conform to the approved abbreviation resource.

(b) Orders should include height/weight/allergy where applicable.

Chemotherapy orders should include patient height, current weight, and body surface area, where applicable.

(c) All PRN orders must include indication and dosing schedule.

(d) Medication orders shall not contain prohibited abbreviations.

g. Diagnostic Radiology Orders

(1) After a reasonable attempt(s) has been made to reach the ordering physician, podiatrist or dentist and unless otherwise specified in the order, and the patient is informed and in agreement, a radiologist may order a diagnostic test in addition to or in lieu of that which is ordered by the treating physician, podiatrist or dentist if, in the radiologist's judgment, the additional or alternative test is medically necessary.

(2) Unless otherwise specified in the order, a radiologist may determine the parameters of a diagnostic test (e.g. use or non-use of contrast media or the number of views).

(3) The radiologist shall document in his/her report why additional or alternative testing was done and/or why the parameters of the test were determined to be as such.

(4) Orders for diagnostic radiology tests may be conditional; that is, they may request an additional test if the result of the first diagnostic test yields a certain result as determined by the ordering physician, podiatrist or dentist.

(5) Ordering physicians, podiatrists or dentists may specify that a diagnostic test must be performed exactly as ordered.

4. Clinical Observations

a. Consultation

(1) The consultation request shall include the reason as stated by the attending physician, podiatrist or dentist. The consultation report shall reflect evidence of a review of the medical record, actual examination of the patient, pertinent findings, opinions, and recommendations.

(2) Refer to "General Standards of Patient Care" for cases in which a consultation is required.

b. Progress Notes

(1) All Medical Staff progress notes shall be dated and signed by the physician, podiatrist or dentist and will give a pertinent chronological order of the patient's course in the hospital.

(2) Whenever possible, each of the patient's clinical problems will be clearly identified in the progress notes as well as results of tests and treatment. They shall be recorded at the time of observation and written to permit continuity of care and transferability of the patient. Progress notes shall be written at least daily. For stays of less than forty-eight (48) hours, a final progress note will be made upon discharge.

(3) There must be evidence on the progress notes of the medical record that includes justification for the performance of surgical procedures, including the documentation of the pre-operative diagnosis and the presence or absence of complications.

(4) Indications for use of blood products must be documented in the medical record.

5. Reports of Procedures, Tests and the Results

a. Operative/Invasive Reports

(1) A comprehensive operative/invasive procedure report must be dictated or written immediately following a surgical or invasive procedure. If dictated, a brief operative/invasive procedure progress note must be hand written in the medical record immediately after surgery in order to provide pertinent information for use by any practitioner required to attend the patient.

(2) The dictated operative/invasive procedure reports should contain the pre- and post-operative diagnoses, the name of the primary surgeon and any assistants, the procedure performed, a detailed description of the procedure performed, to include the technical procedure used, the findings, the specimens removed, estimated blood loss, amount of any blood transfused, complications, and patient's condition on leaving operating room.

(3) The operative/invasive procedure hand-written progress note must contain the pre- and post-operative diagnosis, the name of the primary surgeon and any assistants and the procedure performed.

b. Pathology Reports

(1) The pathologist is responsible for the preparation of a descriptive diagnostic report of gross specimens received from surgical procedures and of autopsies performed. These reports will be signed by the pathologist and made part of the medical record.

(2) When an autopsy is performed, provisional anatomic diagnoses should be recorded in the medical record within three (3) days, and the complete protocol should be made part of the record within sixty (60) days. The pathologist shall sign these reports.

c. Radiology Reports

(1) The radiologist is responsible for the preparation of all radiology reports of examinations performed.
(2) These reports shall be signed by the radiologist and made a part of the medical record.

6. Conclusions

a. Diagnoses
(1) All diagnoses and operations must be recorded using acceptable disease and operation terminology and abbreviations within the approved resource.

b. Final Diagnoses

(1) The patient may not leave the hospital until the principal and additional or associated diagnoses, established by the time of discharge as much as possible, have been recorded.

(2) In the sequence of final diagnoses, the first should explain the reason for the patient's admission to the hospital. The final diagnosis should also include any complications occurring during hospitalization. These, as well as all operative procedures performed, should be recorded on the cover sheet of the medical record and/or in the clinical resume and signed by the physician.

7. Clinical Resume

a. A Clinical Resume or Discharge Summary shall be recorded for all medical records of patients at the termination of their hospitalization (see exceptions below) and signed by the responsible physician.

b. The clinical resume should concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, final diagnoses, the condition of the patient on discharge (stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology, such as "improved"), and any specific instructions given to the patient and/or family, as pertinent, including instructions relating to physical activity, medication, diet and follow-up care (when preprinted instructions are given to the patient,

the record should so indicate and a sample of the instruction sheet in use at the time should be on file in the Health Information Management Department).

c. A clinical resume is required on all patients who expire and should indicate the events leading to death.

d. A final progress note may be substituted for the Clinical Resume on medical records of patients with problems of a minor nature that require less than a forty-eight (48) hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note should include any instructions given to the patient and/or family.

8. Anesthesia Documentation

a. Pre-Anesthesia Assessment

(1) Records of patients scheduled to undergo general anesthesia must show evidence of pre-anesthesia assessment evaluation, which must be recorded by a physician with such privileges prior to pre-operative medication and surgery. If assessment is completed by the CRNA, the plan of care will be reviewed and approved by the physician prior to anesthesia induction.
(2) This evaluation should include the date of the visit, information relative to the choice of anesthesia (must at least refer to the use of general, spinal, or other regional anesthesia), information relative to the surgical or obstetrical procedure anticipated, the patient's prior drug history, the patient's other anesthetic experiences, and any potential anesthetic problems.

b. Anesthesia Administration

(1) The anesthesiologist or CRNA is responsible for documenting all pertinent events taking place during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood or blood components.

(2) If documented by the CRNA, the anesthesiologist will sign on the anesthesia record.

c. Post-Anesthesia Assessment

(1) A member of the Anesthesiology Service will see patients who are admitted to the hospital for greater than twenty-four (24) hours after receiving anesthesia care.

(2) Documentation of the visit and findings shall be recorded in the appropriate section for post-anesthesia visits. Minimum documentation shall include name and signature, date and time of visit, and description of the presence or absence of post-anesthesia complications, description of findings or actions taken, if any, and explanations conveyed to the patient.

9. Countersignature

a. The following entries in the medical record by physician residents and non-physician personnel must be countersigned by the supervisory or attending Medical Staff as noted within twenty-four (24) hours:

(1) History and Physical Examinations;

(2) Consultation;

(3) Operative Report;

(4) Labor & Delivery Record;

(5) Progress Notes

(6) Clinical Resume or Final Progress Note;

(7) Final Diagnosis on Face Sheet.

b. Verbal orders shall be countersigned by the responsible physician within twenty-four (24) hours when such orders prescribe:

(1) Restraints

(2) DNR orders

c. The Medical Staff Executive Committee may from time to time determine other categories of diagnostic or therapeutic verbal orders associated with potential hazards to patients to be countersigned by the responsible physician within the twenty-four (24) hour period.

10. Consents

a. The medical record shall contain evidence of the patient's informed consent for any procedure or treatment for which it is appropriate, including use of blood products. The physician, podiatrist or dentist who informs the patient and obtains the consent should be identified in the medical record.

b. This information should include:

(1) Identity of the patient;

(2) The procedure or treatment to be rendered (layman terminology when possible);

(3) The name(s) of the individuals who will perform the procedure or administer the treatment;

(4) The authorization for any required anesthesia;

(5) An indication that alternate means of therapy and the possibility of risks or complications have been explained to the patient by the physician, podiatrist or dentist;

(6) The authorization for disposition of any tissue or body parts as indicated;

(7) The signature of the patient or other individual empowered to give consent (should be witnessed);

(8) The date and time of the consent.

c. Informed consent must be documented prior to the procedure or treatment and before the patient goes under the influence of narcotics or hypnotic medication.

d. Refer to hospital policy and procedures for specific forms of documentation of informed consent for various procedures and treatment.

11. Release of Records/Protected Health Information (PHI)

a. Medical records are confidential PHI. Disclosure of confidential information, whether in written, electronic or oral form, even inadvertently, may be a violation of state or Federal law (HIPAA) and may subject you and South Lake Hospital to fines and other penalties.

b. Medical records are the property of the hospital and may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute.

c. Unauthorized removal of medical records from the hospital is grounds for suspension of the physician, podiatrist or dentist or such other corrective or disciplinary action which may be taken in accordance with Medical Staff Bylaws.

d. In case of readmission of a patient, all previous records shall be available for use by the attending physician, podiatrist or dentist. This shall apply to each patient's hospitalization whether or not the patient is attended by the same physician or podiatrist.

12. Abbreviations

To avoid misinterpretation, only those symbols and abbreviations within the approved resource may be used in the medical record.

13. Medical Records Requirements for Organ Donation

When a donor organ is obtained from a brain-wave-dead patient, the medical record of the donor includes the date and time of brain-wave death, documentation by and identification of the physicians who determined the death, the method of transfer of the organ and the method of machine maintenance of the patient for organ donation, as well as an operative report.

14. Medical Record Requirements for Ambulatory Care

a. The requirements set forth in this section are in addition to those specified in Article XIII, Section C, Paragraph 5.

b. A medical record will be maintained for every patient who receives ambulatory care services. This record will be made part of the hospital's unit record system.

c. Pertinent information will be recorded and/or updated for each ambulatory care visit. For patients receiving ambulatory care services and rehabilitation therapy, the medical record

will contain a summary list of known significant diagnoses, conditions, procedures, drug allergies, and medications. The list will be initiated by the third visit.

d. The medical record of an ambulatory care patient who has received other than local anesthesia contains documentation that the patient meets established discharge criteria or of an examination performed by a physician prior to discharge. The record also indicates that the patient is accompanied home by a designated person.

15. User Access Code

a. Each Medical Staff member who is granted a User Access Code (UAC) shall be subject to Hospital Policies and Procedures regarding use of such UAC and will be required to sign and comply with such user responsibility statements and user confidentiality statements as required by the hospital.

b. Each Medical Staff member is responsible for all entries made using that member's UAC.

D. CLINICAL DEPARTMENTS

1. Each clinical department shall enact department rules, regulations and policies subject to the approval of the Medical Staff Executive Committee. Such rules, regulations and policies shall not in any way conflict with the Medical Staff Bylaws, Rules and Regulations, or Hospital Bylaws, policies, and procedures.

2. Copies of such department rules, regulations and policies shall be provided to each member of the department and to applicants seeking membership in the department.

3. The department shall review department rules, regulations and policies at least every two (2) years.

Medical Staff Bylaws, Rules & Regulations
Adopted by the Medical Staff
May 20, 2011

Medical Staff Bylaws, Rules & Regulations
Approved by the Board of Directors
May 20, 2011