

MERCYONE SIOUXLAND

MEDICAL CENTER

MEDICAL STAFF BYLAWS

VERSION INITIATED **2011**

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**BYLAWS OF THE MERCYONE SIOUXLAND MEDICAL CENTER
MEDICAL STAFF**

PURPOSE

Whereas, MercyOne Siouxland Medical Center (“MercyOne) Sioux City, Iowa is a member of the Mercy Health Services-Iowa, Corp., a Delaware nonstock corporation doing business in Iowa as a member of the Mercy Health Network.

Whereas, it is recognized that the Mercy Health Network Board of Trustees has delegated to Board the ultimate authority and responsibility for all aspects of the Hospital operations, and, therefore the Medical Staff is accountable to the MercyOne Board for the proper discharge of its responsibilities, and all Medical Staff activities and actions are subject to review and approval by the MercyOne Board, and

Whereas, it is recognized that the Medical Staff is delegated responsibility by MercyOne for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the MercyOne Board’s ultimate authority.

Therefore, the Medical Staff is organized in conformity with these bylaws.

I. DEFINITIONS

- 1.1 ACTIVITY UNIT** An inpatient admission, consultation or outpatient procedure performed by a practitioner at the Hospital.
- 1.2 ADVANCED PRACTICE PROFESSIONAL or APP** A licensed Practitioner (other than a Physician, Dentist or Podiatrist) who has been granted Clinical Privileges at the Hospital. The Board of Trustees, after soliciting the recommendation of the Medical Executive Committee, shall determine from time to time which licensed professions are eligible for APP status. APPs are not members of the Medical Staff. APPs include both individuals who are employed by the Hospital and those who are not.
- 1.3 APPELLANT** A Medical Staff Member, a Practitioner who has been granted Clinical Privileges, or a Practitioner who is applying for Medical Staff membership and/or Clinical Privileges, who has requested Due Process pursuant to Article X or XI, as applicable.
- 1.4 BOARD CERTIFIED or BOARD CERTIFICATION** Certification as a specialist or subspecialist by a certifying board that is recognized as such by the American Board of Medical Specialties, the American Osteopathic Association, or the American Dental Association's Commission on Dental Accreditation, or certification by the American Board of Podiatric Surgery.
- 1.5 BOARD ELIGIBLE OR BOARD ELIGIBILITY** A Practitioner's eligibility to sit for the certification examination offered by a certifying board that is recognized as such by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association's Commission on Dental Accreditation, or the American Board of Podiatric Surgery.

1.6 BOARD OF TRUSTEES or BOARD	The MercyOne Siouxland Medical Center Board established and appointed by the Mercy Health Network Board of Trustees to perform and carry out the duties and responsibilities attributable to MercyOne Siouxland Medical Center.
1.7 CHIEF EXECUTIVE OFFICER or CEO	The highest ranking executive position of the Hospital.
1.8 CHIEF MEDICAL OFFICER or CMO	The physician in the hospital who provides leadership to the Medical Staff in an executive role.
1.9 CLINICAL PRIVILEGES	Authorization granted by the Board of Trustees to a Practitioner, or temporary authorization granted in accordance with these Bylaws, to provide specific form(s) of direct Patient care to Patients in the Hospital.
1.10 CONTRACT PRACTITIONER	A Member who furnishes Patient care services at the Hospital pursuant to a contract between the Member and the Hospital or on behalf of an entity that contracts with the Hospital.
1.11 DAY	Calendar day including Saturdays, Sundays and holidays.
1.12 DENTIST	An individual licensed to practice dentistry.
1.13 DUE PROCESS	The right to utilize the hearing and appellate review procedures described in Article X or Article XI, as applicable.
1.14 EX OFFICIO	Service on a body by virtue of an office or position held. Unless otherwise expressly provided, ex-officio members are without vote and are not counted in determining the existence of a quorum.
1.15 FOCUSED PROFESSIONAL PRACTICE EVALUATION or FPPE	The time-limited evaluation of a Member's or APP's competence in

		performing specific Clinical Privilege(s) and/or professional behavior.
1.16	HOSPITAL	MercyOne Siouxland Medical Center and all locations billed as inpatient or outpatient departments of MercyOne Siouxland Medical Center.
1.17	HOSPITAL-BASED	A department, division or service staffed by Contract Providers.
1.18	MEDICAL EXECUTIVE COMMITTEE or MEC	The executive committee of the Medical Staff.
1.19	MEDICAL STAFF or STAFF	Those Physicians, Podiatrists and Dentists admitted to practice at the Hospital in accordance with these Bylaws.
1.20	MEDICAL STAFF POLICY	A policy adopted by the MEC or Medical Staff which implements the standards stated in these Bylaws or establishes procedures to accomplish the processes described in these Bylaws, and which is consistent with these Bylaws and approved by the Board.
1.21	MEDICAL STAFF YEAR	The period from January 1 to December 31.
1.22	MEMBER	Any professional appointed to and maintaining membership in any category of the Medical Staff in accordance with these Bylaws.
1.23	ONGOING PROFESSIONAL PRACTICE EVALUATION or OPPE	Ongoing collection, verification and evaluation of data relevant to a Member's or APP's clinical competence and professional behavior.

- 1.24 ORAL SURGEON** An individual who has successfully completed a residency program in oral and maxillofacial surgery accredited by the American Dental Association's Commission on Dental Accreditation, and who is licensed in Iowa to practice dentistry and oral and maxillofacial surgery. (*Licensure requirements vary from state-to-state.*)
- 1.25 PATIENT** Any person undergoing diagnostic evaluation or receiving medical treatment under the auspices of the Hospital.
- 1.26 PHYSICIAN** An individual who is licensed to practice allopathic or osteopathic medicine.
- 1.27 PODIATRIST** An individual who is licensed to practice podiatric medicine and surgery.
- 1.28 PRACTITIONER** A Physician, Dentist, or Podiatrist, or an individual licensed in a profession that is eligible for Advanced Practice Professional status.
- 1.29 RESIDENT AFFILIATE** A Physician in residency training or in a fellowship, who is under direct or indirect contract with the Hospital to provide specified limited services in the Hospital. Resident Affiliates may provide services only within the scope of their Clinical Privileges, and are not Members of the Medical Staff.
- 1.30 RULES** All Medical Staff Policies, the Rules and Regulations, and Hospital policies applicable to Practitioners in the Hospital, collectively.
- 1.31 RULES AND REGULATIONS** The Rules and Regulations of the Medical Staff and of Medical Staff departments, adopted in accordance with these Bylaws.

1.32 SPECIAL NOTICE

Written notice that is (a) delivered personally, (b) sent by registered or certified mail, return receipt requested, or (c) sent by overnight delivery service, to the person to whom the notice is directed.

References to the President of the Medical Staff, Department Chair, Chief Medical Officer, and Credentials Committee Chair include their respective designee when the named individual is not available. Where the masculine gender is used, the term represents either the masculine or feminine gender.

II. MEDICAL STAFF MEMBERSHIP

2.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff and Clinical Privileges (including temporary Clinical Privileges) are privileges, not rights, that are extended only to Practitioners whom the Hospital determines continuously meet the qualifications and satisfy the requirements stated in these Bylaws. Decisions on membership and Clinical Privileges are made by the Board, in its discretion, acting on the recommendation of the MEC. No Practitioner shall be entitled to Medical Staff membership or Clinical Privileges merely by virtue of licensure to practice a profession, Board Certification or Board Eligibility, membership in any professional organization, Clinical Privileges at another health facility, prior membership or Clinical Privileges at the Hospital, or contract. Decisions regarding Medical Staff membership and Clinical Privileges will not be based on race, color, sex, national origin, religion, age and any other criterion prohibited by law. A Member may furnish Patient care at the Hospital only within the limits of the Clinical Privileges granted in accordance with these Bylaws.

2.2 BASIC QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

A Practitioner's application for Medical Staff membership will be returned unprocessed if the Practitioner fails to satisfy any of the following basic qualifications for membership:

2.2.1 Holds an unrestricted license in any state in which the practitioner is actively practicing.

2.2.2 Holds an unrestricted DEA registration and an Iowa controlled substances license, if the applicant seeks Clinical Privileges to prescribe controlled substances or if such registration or license is required by the department to which the applicant likely would be assigned.

2.2.3 Maintains and provides proof of professional liability insurance as required by the Board. The minimum insurance limits are \$1,000,000 per occurrence and

\$3,000,000 annual aggregate. Certificate of insurance must be provided to the Medical Staff office when coverage is renewed.

2.2.4 If the applicant is a Physician or Podiatrist, has completed a residency that satisfies the Hospital's requirements.

2.2.5 Is not excluded from any federal health care program, such as Medicare or Medicaid.

2.3 OTHER CRITERIA FOR MEDICAL STAFF MEMBERSHIP

In addition to the basic qualifications stated in Section 2.2, the following criteria are evaluated in acting upon each application for Medical Staff membership:

2.3.1 The applicant's education, training, experience, judgment, health status, character, and demonstrated competence are sufficient to enable the applicant to provide high quality, efficient, cost-effective, and ethical medical care and to exercise capably the Clinical Privileges requested. The evidence which is relevant to these criteria includes:

2.3.1.1 Challenges to any licensure or registration.

2.3.1.2 Voluntary and involuntary relinquishment of any license or registration.

2.3.1.3 Voluntary and involuntary termination of medical staff membership at any facility.

2.3.1.4 Voluntary and involuntary limitation, reduction, or loss of clinical privileges at any facility.

2.3.1.5 Professional liability actions, either pending or resulting in a final judgment or settlement payment with respect to the applicant.

2.3.1.6 Peer and/or faculty references.

2.3.1.7 Relevant Practitioner-specific data as compared to aggregate data, when available.

2.3.1.8 Morbidity and mortality data, when available.

2.3.2 The applicant is able and willing to work cooperatively with other health care professionals and Hospital personnel and to maintain a good relationship with his Patients.

2.3.3 The applicant adheres to the ethics of his profession.

2.3.4 The applicant provides documentation of arrangements with another Member who holds appropriate Clinical Privileges and who will provide coverage for the

applicant's Patients when the applicant is unavailable. The alternate must be in the same Department/specialty with like privileges. If there is no other physician on staff to cover, another physician may provide backup with MEC approval.

2.3.5 The applicant's office and residence will be sufficiently close to the Hospital to enable the applicant to maintain continuity of care for his Patients and be readily available to fulfill the responsibilities of Medical Staff membership.

2.3.6 The Hospital will also consider the needs of the Hospital and the community it serves, any relevant Hospital contractual obligations, and the availability at the Hospital of adequate facilities and resources to support each Privilege requested.

2.4 RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Each Member shall continuously fulfill the following responsibilities:

2.4.1 Provide his Patients with care in the Hospital at the generally recognized level of quality and efficiency, including arranging for consultations when appropriate, providing daily care and supervision for Hospital inpatients who are under his care, and providing coverage at all time for his Patients who are in the Hospital or who present at the Hospital (either personally or through arrangements with another qualified Member).

2.4.2 Abide by these Bylaws, the Rules (including the Professional Behavior Policy), Trinity Health's Corporate Compliance Plan, and the ethical code of the Member's profession.

2.4.3 Abide by the ethical and religious directives for Catholic health facilities.

2.4.4 Participate in Staff activities, at a level consistent with his Staff category, and carry out all duties for which the Member is responsible by appointment, election or otherwise.

2.4.5 Treat employees, Patients, volunteers, visitors and other Practitioners at the Hospital in a dignified and courteous manner.

2.4.6 Timely complete medical and other records for which he is responsible, in accordance with the current standards and regulations.

2.4.7 Perform a timely inpatient consultation within the scope of his Clinical Privileges at the request of the Member treating the Patient.

2.4.8 Comply with applicable state and federal laws and regulations.

2.4.9 Be available to furnish emergency care at the Hospital in accordance with the Rules.

2.4.10 Report any of the following events in writing to the Chief Medical Officer within fifteen (15) Days after it occurs: (a) the Member is convicted of (or pleads guilty

or no contest to) a felony, (b) disciplinary action is imposed on the Member by a licensed health facility, (c) the Member resigns or limits his clinical privileges at a licensed health facility while under investigation or in order to avoid an investigation or proceedings, (d) the Member's license to practice a health profession or to prescribe drugs in any jurisdiction is terminated, limited, placed on probation, relinquished, or lapses, or (e) payment is made in settlement or judgment of a professional liability claim against the Member.

2.4.11 Comply with the following requirements with respect to the Member's Patients: A physical examination and medical history must be completed and documented for each Patient no later than twenty-four (24) hours after the Patient is admitted or registered, and in any event before the Patient undergoes surgery or a procedure that requires anesthesia. A history and physical performed no more than thirty (30) days before the Patient was admitted or registered may be used, provided an updated examination of the Patient is completed and documented no later than twenty-four (24) hours after admission or registration, and in any event before the Patient undergoes surgery or a procedure that requires anesthesia. A history and physical exam required by this Section must be performed by an individual who holds Clinical Privileges to perform histories and physicals. Additional requirements regarding histories and physicals are contained in the Rules.

2.4.12 All applicants are required to be board certified/board eligible in at least one specialty in their primary area of practice by the appropriate specialty/subspecialty board of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the Commission on Dental Accreditation, the American Board of Oral & Maxillofacial Surgery, the American Board of Podiatric Surgery, College of Family Physicians of Canada, and the Royal College of Physicians & Surgeons of Canada. Those applicants who are not board certified at the time of application must become Board eligible within 2 years of appointment and Board certified within 5 years to maintain medical staff membership. Providers must maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed on an ongoing basis and at the time of applicable specialty/subspecialty board certification expiration. All current members of the Medical Staff who have held membership at MercyOne since 2002 and are not board certified as of 2016 shall be grandfathered and may maintain medical staff membership. If at any time board certification becomes a requirement for the hospital to maintain its credentials or financial reimbursement, board certification will be required of all members regardless of number of years of membership."MercyOne

2.4.13 Use the Hospital's name in advertising and otherwise only in accordance with applicable Board policy.

2.4.14 Timely pay Medical Staff dues as established by the Medical Staff.

2.5 DURATION OF MEMBERSHIP

2.5.1 Appointment. All initial appointments and reappointments to the Medical Staff shall be for a term of up to twenty-four months.

2.5.2 Contract Practitioners. A Contract Practitioner's Clinical Privileges to perform those Patient care services covered by the contract with the Hospital shall terminate automatically, without Due Process, upon termination of the contract with the Hospital or upon termination of the Practitioner's association with the entity that contracts with the Hospital; if all of a Contract Practitioner's Clinical Privileges are terminated in this manner, the Contract Practitioner's Medical Staff membership shall also terminate automatically.

2.6 LEAVE OF ABSENCE

Request for Leave of Absence. Any Practitioner (excluding Contract Practitioner) may take leave of absence from the Medical Staff for a period of not more than twelve (12) months by notifying the Medical Staff President and the CEO, in writing, of the date of commencement, expected duration, reasons for the leave of absence and identify the Practitioners who will cover his/her Patients who present themselves to MercyOne Siouxland Medical Center. Any Practitioner in a category other than Honorary who expects to be absent from his or her practice at the Hospital for eight (8) consecutive weeks or longer shall notify the Hospital and request a leave of absence, as provided above.

During a period of leave of absence, no payment of dues or participation in Medical Staff activities shall be required, and all clinical privileges, inpatient, and outpatient privileges shall be suspended. The Practitioner can order lab and non-invasive tests only. Return from leave of absence shall be in accordance with conditions established by the Medical Executive Committee, which may include, as appropriate, health assessment or demonstration of current compliance with all qualifications for privileges.

2.6.1 Reinstatement. At least 45 Days prior to expiration of the leave of absence, or at any earlier time, the Member may submit to the President of the Medical Staff a written request for reinstatement of Clinical Privileges. In addition, the Member shall submit a written summary of the Member's relevant activities during the leave. If a leave of absence was due to illness, the Member shall submit a letter from the Member's attending Physician stating that the Member is physically and mentally able to safely resume full professional practice; the MEC or Board may require additional satisfactory evidence of physical and mental status. A request for reinstatement shall be submitted and processed in the manner specified for reappointment to the Medical Staff. Failure, without good cause, to request reinstatement at least 45 Days prior to the expiration date of the leave of absence or failure to provide requested information shall result in automatic termination of Medical Staff membership and all Clinical Privileges. If the Board (a) denies a request for reinstatement from a leave of absence, (b) reinstates the Member but with reduced Clinical Privileges, or (c) takes any other action listed in Section 10.2.1 of these Bylaws with respect to the Member, the Member shall be entitled to Due Process.

2.6.2 Expiration of Appointment. If a Member's term of appointment will expire during a leave of absence, the Member may apply for reappointment during the

leave in accordance with Section 4.2. The Board may condition reappointment on the Member submitting, at the time of requested reinstatement, acceptable evidence of the Member's ability to perform the Clinical Privileges granted or satisfying other requirements specified by the Board; imposition of such a condition will not entitle the Member to Due Process. Reappointment of a Member does not guarantee that the Member's request for reinstatement from leave of absence will be granted. If a Member on leave of absence does not submit a timely application for reappointment, Medical Staff membership will expire; the individual may later apply for Medical Staff membership and will be treated as a new applicant.

III. MEDICAL STAFF CATEGORIES

3.1 CATEGORIES

The Medical Staff shall be divided into the following categories: Active, Courtesy, Referring, Honorary, Advanced Practice Professional, Resident Affiliate, and Inactive. Each Member shall be assigned to a specific category.

3.2 ACTIVE STAFF

3.2.1 Qualifications: The Active Staff category consists of independent Practitioners, each of whom:

3.2.1.1 Meet all the requirements for the appointment and reappointment process as independent practitioners and are licensed in the State of Iowa.

3.2.1.2 Is located closely enough to the Hospital to provide continuous care to their Patients within thirty (30) minutes.

3.2.1.3 Regularly admits Patients to or is otherwise regularly involved in the care of Patients in the Hospital.

3.2.2 Prerogatives: Each Member of the Active Staff may:

3.2.2.1 Clinical Privileges. Exercise Clinical Privileges, including admitting Clinical Privileges without limitation and may treat Patients within limits of their assigned Clinical Privileges.

3.2.2.2 Meetings/Voting. Be entitled to vote, hold office, serve on Medical Staff committees, and attend Medical Staff and department meetings.

3.2.2.3 Office. Hold office in the Medical Staff and in the department, section and committees of which he/she is a member only after being a Member on the Medical Staff for a period of one year.

3.2.3 Responsibilities: Each Member of the Active Staff shall:

3.2.3.1 Basic Responsibilities. Provide Patient care within approved standards of care. Care for unassigned Patients within an equitable and fair system. Accept emergency service referrals as assigned.

3.2.3.2 Medical Staff Functions. Actively participate in the quality assessment, improvement and safety activities of the Medical Staff, in monitoring the professional performance of Practitioners at the Hospital, and in such other Medical Staff functions as may from time to time be assigned.

3.2.3.3 Committees. Be willing to serve on committees as assigned.

3.2.3.4 Meetings. Attend departmental meetings on a regular basis as specified in these Bylaws.

3.2.3.5 Dues. Pay dues and assessments as determined by the Medical Staff.

3.3 COURTESY STAFF

3.3.1 Qualifications: The Courtesy Staff category consists of independent Practitioners each of whom:

3.3.1.1 Meets all requirements of the appointment and reappointment process as an independent Practitioner and holds a valid state license to practice medicine.

3.3.1.2 Is located closely enough to the Hospital, or otherwise arranges, to provide continuous care to his/her Patients.

3.3.1.3 Is otherwise eligible for Medical Staff membership as herein provided, but who only occasionally admits Patients to the Hospital or who acts only as a consultant and has less than 25 Patient contacts per year.

3.3.1.4 Is a member of the Active Staff at another hospital in Sioux City, unless participating in another community and actively participates in a quality assurance function similar to that required by Active Staff Members of the Hospital.

3.3.2 Prerogatives: Each Member of the Courtesy Staff may:

3.3.2.1 Clinical Privileges. Exercise such Clinical Privileges, including admitting Clinical Privileges under the same conditions as Active Staff Members within the limits of their assigned clinical privileges. At times of full Hospital occupancy or shortage of hospital beds or other resources, as determined by the Chief Executive Officer, the elective Patient admissions of Courtesy Staff Members shall be subordinate to those of Active Staff Members. If a Courtesy Staff Member has more than 25 Patient contacts at the Hospital within one year, he/she must serve on the Active Staff with its rights and obligations.

3.3.2.2 Meetings/Voting. Attend meetings of the Medical Staff in the department of which he/she is a member, but may not vote, except on committees of which he is a member.

3.3.2.3 Office. Courtesy Staff Members may not hold office.

3.3.3 Responsibilities: Each Member of the Courtesy Staff shall:

3.3.3.1 Basic Responsibilities. Have the same Patient care responsibilities and privileges as the Active Staff.

3.3.3.2 Medical Staff Functions. Participate in quality improvement and safety activities of the Medical Staff and discharge such other Medical Staff functions as may from time to time be assigned.

3.3.3.3 Committees. Be eligible to serve on Medical Staff committees.

3.3.3.4 Meetings. Attend meetings of those committee(s) of which he agrees to be a member, but is not otherwise required to attend meetings.

3.3.3.5 Dues. Pay dues and assessments as determined by the Medical Staff.

3.4 REFERRING STAFF

3.4.1 Qualifications: The Referring Staff category consists of independent Practitioners who live beyond the range for providing continuous care and wish to participate in Medical Staff activities. Referring Staff must be an appointee of the active medical staff of another hospital and hold a valid state license to practice medicine. Referring Staff must provide confirmation of state licensure and liability insurance and must also provide a summary of educational and practice history (curriculum vitae).

3.4.2 Prerogatives: A Member of the Referring Staff:

3.4.2.1 Clinical Privileges. Is not eligible for any Clinical Privileges, including admitting Clinical Privileges, but may review the case of his/her Patients who have been referred to or hospitalized at the Hospital. Said case review may include conferring with Physicians and/or nurses involved in the treatment and care of said Patients and chart review, but shall not include any inpatient treatment privileges. Referring Staff may order lab and non-invasive tests within the scope of an Iowa license.

3.4.2.2 Meetings/Voting. Is not required to attend meetings but may attend Medical Staff and department meetings in the Hospital or Medical Staff educational meetings or social events. Referring staff shall not be eligible to vote and may not serve upon committees.

3.4.2.3 Office. May not hold Medical Staff, department, section or committee office.

3.4.2.4 Hospital Facilities. May use the Hospital medical library and dining rooms and attend CME programs at the Hospital.

3.4.2.5 Responsibilities. Must maintain medical licensure and proof of liability insurance coverage in good standing. Proof of current licensure and professional liability insurance must be provided whenever coverage is renewed. An appointee to this category will go through the initial appointment credentialing process for approval but does not require reappointment. Referring Staff must comply with any policy applicable to his/her use of Hospital facilities.

3.5 HONORARY STAFF

3.5.1 Qualifications: The Honorary Staff category consists of those Members who were Members in the Active Staff category at the Hospital for at least 15 years. They are recognized for outstanding reputation, noteworthy contributions to the health and medical sciences or previous long standing service to the Hospital as an Active Staff Member. Honorary Staff Members are not required to undergo credentialing.

3.5.2 Prerogatives: A Member of the Honorary Staff:

3.5.2.1 Meetings/Voting. May attend Medical Staff, department and section meetings, but may not vote.

3.5.2.2 Office. May not hold Medical Staff, department, section or committee office.

3.5.2.3 Hospital Facilities. May use the Hospital medical library and dining rooms and attend CME programs at the Hospital.

3.5.2.4 Responsibilities. Must comply with any policy applicable to his/her use of Hospital facilities.

NON MEMBERS OF THE MEDICAL STAFF

3.6 ADVANCED PRACTICE PROFESSIONALS

3.6.1 Assignment, Supervision and Compliance. Although responsible to the Medical Staff and the Board, Advanced Practice Professionals are not Members of the Medical Staff. Each APP shall exercise only those Clinical Privileges granted to him by the Board upon recommendation of the MEC, except as otherwise permitted by Sections 5.4 through 5.6. Each APP acts under the overall supervision of a designated Physician Member, Podiatrist Member, or Oral Surgeon Member of the Medical Staff. The APP shall immediately notify the President in writing if the APP's supervisory arrangement with the designated Member ends. An APP may not be granted Clinical Privileges that exceed those of the Member who supervises the APP. The Hospital may grant Clinical Privileges that are less extensive than the scope of activities an APP is licensed to perform. APPs shall

comply with these Bylaws, the Rules, and any Hospital policy intended to govern their activities.

3.6.2 Qualifications. APPs must possess a license or registration to practice their profession in the State of Iowa, if applicable. Applications for initial and renewed Clinical Privileges will be processed using the procedures and criteria set forth in Articles IV and V (subject, however, to Due Process in accordance with Article XI, rather than Article X) to the extent applicable to the Practitioner's profession.

3.6.3 Meeting Attendance. APPs may attend meetings of the Medical Staff and/or their department at the request of their supervising Member and subject to the approval of the individual presiding at the meeting. If so permitted to attend a meeting, APPs may not vote, nor may they otherwise participate unless requested by the presiding officer.

3.6.4 Suspension and Termination. An APP's Clinical Privileges may be suspended, revoked, or not renewed (including action pursuant to Articles VI through IX) in the same manner as a Member of the Medical Staff (subject, however, to Due Process in accordance with Article XI, rather than Article X), as well as in accordance with the terms of any written contract the APP may have with the Hospital. If (a) the designated supervising Member ceases to be a Member of the Medical Staff, (b) the supervising arrangement (such as, collaboration agreement or employment) between the APP and the designated supervising Member terminates, or (c) the APP ceases to be an employee of the Hospital, if applicable, then the APP's Clinical Privileges shall terminate automatically, without Due Process. The events described in (a) and (b) will not result in automatic termination of the APP's Clinical Privileges if the Board (acting on the MEC's recommendation) immediately approves a substitute supervising Member.

3.7 RESIDENT AFFILIATES

3.7.1 Assignment, Supervision and Compliance. Although responsible to the Medical Staff and the Board, Resident Affiliates are not Members of the Medical Staff. Each Resident Affiliate shall exercise only those Clinical Privileges granted to him/her by the Board upon recommendation of the MEC, except as otherwise permitted by Sections 5.4 through 5.6. Each Resident Affiliate acts under the overall supervision of the attending Physician to whom assigned. When participating in the care of a Patient admitted to the Hospital, the Resident Affiliate shall work under the supervision of the attending Member. Resident Affiliates shall comply with these Bylaws, the Rules, and any Hospital policy intended to govern their activities.

3.7.2 Qualifications. Resident Affiliates must possess a resident license to practice allopathic or osteopathic medicine in the State of Iowa during their first year of residency. Resident Affiliates must possess a permanent license after the first year (2nd year for ECFMG graduates) and must hold faculty appointment with an established residency program. Applications for initial and renewed Clinical Privileges will be processed using the procedures and criteria set forth in Articles IV and V, excluding those relating to completion of a residency and Board Certification and Eligibility. The Board

grants or denies Clinical Privileges to prospective Resident Affiliates, upon recommendation of the MEC.

3.7.3 Meeting Attendance. Resident Affiliates may attend meetings of the Medical Staff and/or their department at the request of their attending Physician and subject to the approval of the individual presiding at the meeting. If so permitted to attend a meeting, Resident Affiliates may not vote, nor may they otherwise participate unless requested by the presiding officer.

3.7.4 Suspension and Termination. A Resident Affiliate's Clinical Privileges may be suspended, revoked, or not renewed (including action pursuant to Articles VI through IX) in the same manner as a Member of the Medical Staff (subject, however, to Due Process in accordance with Article XI, rather than Article X), as well as in accordance with the terms of any written contract the Resident Affiliate may have with the Hospital

3.8 INACTIVE STAFF

Appointees of the Medical Staff who have left town, or have resigned from clinical practice, may request Inactive Staff status. At the time of their next routinely scheduled reappointment, all persons meeting the above criteria will automatically be assigned to Inactive Staff status regardless of whether they have requested such status.

IV. APPLICATIONS FOR MEDICAL STAFF MEMBERSHIP

4.1 INITIAL APPLICATION

4.1.1 Application Form. Each application for appointment to the Medical Staff shall be submitted on the form approved by the MEC and Board, and signed by the applicant. The application will elicit information relevant to the qualifications and criteria described in Sections 2.2 and 2.3 above, shall indicate the Medical Staff category and Clinical Privileges requested, and shall include the applicant's statement that no health problem exists that could affect his/her ability to safely perform the Clinical Privileges requested.

4.1.2 Effect of an Application. Submission of an application for Medical Staff membership constitutes the applicant's agreement to be bound by the terms of these Bylaws if he/she is granted membership, and by the terms of the Bylaws relating to consideration of his/her application (including Section 5.7) whether or not he/she is granted Medical Staff membership.

4.1.3 Applicant's Responsibilities. The applicant is responsible for producing adequate information for a proper evaluation of his/her qualifications and for resolution of any doubts about his/her qualifications. The applicant shall notify the Medical Staff Office immediately in writing of any change to information contained in the application that occurs while the application is pending. The applicant may be required by the Credentials

Committee, MEC or Board to appear for an interview regarding his/her application or related matters and/or to submit answers to written questions posed by those bodies.

4.1.4 Credentials Verification. An application is complete when the Hospital has received and verified all information specified in Medical Staff Policy. After the Hospital has verified the applicant's credentials and identity and obtained written peer recommendations and a National Practitioner Data Bank report, the complete application shall be referred to the chair of the department in which the applicant seeks Medical Staff membership and/or Clinical Privileges.

4.1.5 Material Omission or Misrepresentation. Any material omission or misrepresentation by an applicant in connection with his application shall be grounds for return of the application, which shall be deemed a withdrawal of the application, with no right to Due Process.

4.1.6 Interview. The chair of the applicable department shall review the applicant's qualifications. The department chair may interview the applicant. The department chair shall submit a written report and recommendation (as defined in Section 4.1.12) to the Credentials Committee.

Credentials Committee Action. The Credentials Committee shall review the applicant's qualifications. The Credentials Committee may also interview the applicant.

If the applicant refuses to meet informally with the Credentials Committee, or attaches conditions to the meeting, refuses to meet without an attorney present, or does not answer questions relevant to past behavior or clinical competence, or if the applicant fails to appear for a scheduled meeting, the Credentials Committee should inform the applicant that his/her application is incomplete and that further processing will be suspended until the applicant responds to their questions. The Credentials Committee will not forward a recommendation on an application that is not complete.

The department and credentials committee chairpersons will review each application and its associated information, and will categorize the applicant as a Category I or II applicant as defined in the Medical Staff Credentialing & Privileging Manual. The procedure for processing Category I and II applicants will occur as follows:

For Category I applicants, the department chair and Credentials Committee chair forward a report with findings and a recommendation to the MEC for its review and recommendations. The MEC will forward its recommendations to the Board or Board representatives who are delegated by the Board to review Category I applicants and make a formal decision. If the department chair's recommendation is negative or differs from that of the Credentials Committee chair or MEC, the application is automatically classified as a Category II and processed accordingly.

For Category II applicants, the application is forwarded to the appropriate department chair for review and recommendation. The department chair reviews the application to make sure it meets the established standards for membership and clinical privileges

The chairperson may meet with the applicant to discuss any aspect of the application, the applicant's qualifications and clinical privileges requested before making a recommendation to the Credentials Committee. The department chairperson's report will be in writing, signed and dated.

The department chair forwards the application and report to the Credentials Committee for review and recommendation. The Credentials Committee reviews the application for membership and clinical privileges.

If there is any question concerning the applicant's physical or mental health, the Credentials Committee has a right to require a physical or mental examination of the applicant by a Physician satisfactory to the Committee, who will submit a report to the Committee before it makes a recommendation.

4.1.7 The Credentials Committee shall submit its written report and recommendation, along with the department chair's report and recommendation, to the Medical Executive Committee. The chairperson of the Credentials Committee, or another designated member of the Committee, should be available to the Medical Executive Committee to answer any questions that may be raised with respect to the Committee's recommendation. The department chairperson's assessment report will accompany the Credentials Committee's recommendation. The MEC forwards the application with its recommendations to the Quality Committee of the Board and to the Governing Board for final action.

4.1.8 Medical Executive Committee Action. Upon receipt of the report of the Credentials Committee, the Medical Executive Committee shall review the reports of the Credentials Committee and department chair and other relevant information. The MEC shall submit its written report and recommendation to the Board. If the MEC disagrees with the recommendation of the Credentials Committee, the MEC shall also deliver to the Board a copy of the reports and recommendations of the Credentials Committee and the department chair.

4.1.9 Board Action. Upon receipt of the Medical Executive Committee's recommendation, the Board or its delegated representatives (consisting of a minimum of two members) may approve the reappointment and clinical privileges as recommended. The Board has final authority for all appointments to the Medical Staff and for granting Clinical Privileges. It is the Hospital's and Medical Staff's goal that applications typically be acted on by the Board within 60 Days after the application is complete, recognizing however that a longer period may be needed in some cases, for example, to evaluate an applicant's credentials or to complete Due Process. Clinical Privileges are determined in accordance with Article V. The Board shall either (1) adopt the recommendation of the Medical Executive Committee, or (2) refer it back to the MEC for further consideration with a statement of the reason(s) for such action. If an application is referred back, the

MEC shall again make a written report and recommendation to the Board, which shall consider the recommendation before taking final action on the application.

4.1.10 Adverse Recommendations. If the MEC makes an adverse recommendation or the Board makes a preliminary adverse decision with respect to an application, the applicant may request Due Process. If an applicant who is the subject of an adverse preliminary decision does not make a timely request for a hearing or is not entitled to a hearing, the application is considered to have been withdrawn and shall not receive further consideration. If a decision is unfavorable with respect to scope of Clinical Privileges only, an applicant who either does not timely request a hearing or is not entitled to a hearing, will be deemed to have requested only those Clinical Privileges the Board is willing to grant.

4.1.11 Reapplication. A Practitioner whose application for Medical Staff membership is deemed withdrawn pursuant to Section 4.1.5 or 4.1.10 or whose application is denied shall not be eligible to reapply to the Medical Staff for a period of 2 years, unless the Board specifies otherwise.

4.1.12 Reports and Recommendations. As used in this Article, “written report and recommendation” means a written recommendation regarding Medical Staff appointment and, if appointment is recommended, Staff category, Clinical Privileges to be granted, and any special conditions to be attached to the appointment, with the reasons for any unfavorable recommendation stated in writing.

4.2 PROCEDURE FOR REAPPOINTMENT

4.2.1 Reappointment Application. Each Member who desires reappointment to the Medical Staff shall submit a timely, signed and complete reappointment application to the Hospital in accordance with Medical Staff Policy on a form approved by the MEC and Board. The application will indicate the Medical Staff category and Clinical Privileges requested. If a timely and complete reappointment application is not submitted, the Member’s Medical Staff membership and Clinical Privileges will expire at the end of the current term of appointment. The reappointment application will require submission of information that will allow a determination of whether the Member meets the ongoing qualifications for Medical Staff membership and for requested Clinical Privileges, including providing reasonable evidence of current ability to perform capably the Clinical Privileges requested and information concerning any changes in the Member’s qualifications since his last (re)appointment.

The reappointment term shall be for an interval no longer than two years. It shall be based on the applicant’s birthday month in the appropriate odd or even numbered year.

4.2.2 Reappointment Criteria. The reappointment process will include evaluation of:

4.2.2.1 The Member’s professional performance and judgment.

4.2.2.2 The Member's current clinical and technical skills and competence to perform the Clinical Privileges requested, as measured in part by the results of the Hospital's performance improvement activities and ongoing professional practice evaluation, and as assessed by the applicable department chair.

4.2.2.3 Professional ethics and conduct, including compliance with the Bylaws and Rules, and working relationships with others at the Hospital.

4.2.2.4 Current appraisal of the Practitioner's physical and mental health.

4.2.2.5 Compliance with Activity Unit requirements applicable to the Medical Staff category requested by the Practitioner. Applicants with little or no clinical activity at the Hospital must be evaluated with a report from the applicant's primary hospital affiliation verifying the applicant is competent to perform privileges requested, and has complied with their medical staff bylaws, rules, and regulations.

4.2.2.6 All information supplied in the Member's reappointment application.

4.2.3 Processing Reappointment Applications. Applications for reappointment shall be processed in the same manner as initial applications, using the procedures described in relevant portions of Section 4.1 of these Bylaws, except interviews of the applicant are not routinely required. The consequences of failure to complete or follow Bylaw requirements during the reapplication process shall be identical to the consequences of failure to complete or follow requirements during initial application for membership and Clinical Privileges.

4.2.4 Medical Executive Committee Input Required. The Board will not take action on an application for reappointment without first seeking the recommendation of the Medical Executive Committee with respect to the application.

4.2.5 Board Action. The Board shall take final action on applications for reappointment and renewal of Clinical Privileges, except that no final action may be taken with respect to any Member as to whom an adverse recommendation or decision has been made who has not either waived or completed the Due Process provided for in Article X, if applicable.

V. CLINICAL PRIVILEGES

5.1 DELINEATION OF CLINICAL PRIVILEGES

5.1.1 Clinical Privileges Are Required. Each Member shall exercise only those Clinical Privileges granted to him by the Board upon recommendation of the MEC, except as otherwise permitted by Sections 5.4 through 5.6.

5.1.2 Criteria. Requests for Clinical Privileges shall be evaluated on the basis of the factors and categories of information listed in Sections 2.2, 2.3 and 4.2.2. In addition, the applicant's request for privileges will be within the Hospital's current scope of patient care services. Privilege determinations shall take into account pertinent information concerning clinical performance obtained from other sources, especially from other institutions and health care settings where the Practitioner has exercised Clinical Privileges. The Practitioner has the burden of establishing his qualifications and competency in the Clinical Privileges he requests. The Clinical Privileges available within a department and the specific qualifications required for each Privilege shall be recommended by the department chair and approved by the MEC and Board.

5.1.3 Dentists and Oral Surgeons. A Member who has history and physical Clinical Privileges shall perform the required history and physical exam of a dental or oral surgery Patient. In all cases a Physician Member shall be responsible for the care of any medical problem that is present at the time of admission or that arises during hospitalization, and shall be identified in the medical record by the Oral Surgeon/Dentist at the time of admission.

5.1.4 Podiatrists. Podiatrist Members shall be assigned to the Department of Surgery. A podiatric Patient may be admitted by a Podiatrist Member who has admitting Clinical Privileges. A Member who has history and physical Clinical Privileges shall perform the required history and physical exam of a podiatric Patient. In all cases a Physician Member shall be responsible for the care of any medical problem that is present at the time of admission or that arises during hospitalization, and shall be identified in the medical record by the Podiatrist at the time of admission.

5.1.5 Non-Members. Clinical Privileges may be granted to Non-Members pursuant to Sections 5.4 and 5.6 and Article III. Non-Members may not be granted admitting Clinical Privileges, except as otherwise permitted by Sections 5.4 and 5.6. A non-Member may participate in the care of Patients, including performance of histories and physicals, only in accordance with the scope of Clinical Privileges granted to the non-Member in correlation with known state and federal regulations.

5.2 PRIVILEGE MODIFICATION

5.2.1 Privilege Increase. A Member may request an increase in Clinical Privileges during the term of his appointment by submitting a written request in accordance with Medical Staff Policy. Any such request will be processed using substantially the same procedures as for a request for reappointment.

5.2.2 Privilege Decrease. A Member may request a decrease in Clinical Privileges during the term of his appointment by written request to the Credentials Committee. The Credentials Committee shall promptly notify the MEC and the Board of any Privilege reduction request that it approves.

5.3 FOCUSED PROFESSIONAL PRACTICE EVALUATION

Each new applicant will be under Focused Professional Practice Evaluation (FPPE) according to the Medical Staff Policy for OPPE/FPPE. FPPE will occur in all requests for new privileges and when there are concerns regarding the provision of safe, high quality care by a Member (may be identified through Ongoing Professional Performance Evaluations). FPPE will also be implemented when a privilege is used infrequently. Approximately six (6) months after a Practitioner's initial appointment (or the granting of new privileges in an existing Staff Member), the Medical Staff department chair/designee will review the Practitioner-specific competency profile report and the completed FPPE Case Review Forms.

Each Member shall be assigned to a department where his/her performance shall be proctored by the chairperson of the department or such chairperson's designee. The assigned proctor/designee will be responsible for making recommendations for conclusion of FPPE and for the applicant's staff status change.

5.4 TEMPORARY CLINICAL PRIVILEGES

5.4.1 Procedures. A Practitioner may be granted temporary Clinical Privileges by the CEO, with the concurrence of the President of the Medical Staff or his/her designee, and the chair of the relevant department. Practitioners who hold temporary Clinical Privileges are not Members. Temporary Clinical Privileges shall be granted only (a) when the information available reasonably supports a favorable determination regarding the requesting Practitioner's qualifications, competence and judgment to exercise the Clinical Privileges requested, (b) after the Practitioner has provided evidence of professional liability insurance as required by the Board, and (c) after the Practitioner's license has been verified. Temporary Clinical Privileges must be for a specified time period, consistent with the time limits stated in this Section.

5.4.2 Types of Temporary Clinical Privileges. Temporary Clinical Privileges may be granted in the following circumstances:

5.4.2.1 Pendency of Application. If a complete application for Staff appointment (or, in the case of an APP or Resident Affiliate a complete application for Clinical Privileges) has been approved by the relevant department chair, the individuals listed in Section 5.4.1 may grant the applicant temporary Clinical Privileges during the pendency of the application or for up to 120 Days, whichever is shorter. An applicant is eligible for temporary Clinical Privileges under this Section only if he is not/has not been subject to licensure sanction, adverse action on medical staff membership or privileges at another facility, or any other disqualifying criteria specified in Medical Staff Policy.

5.4.2.2 Treatment of Specific Patient(s). Upon the request of a Member, the individuals listed in Section 5.4.1 may grant temporary Clinical Privileges to a qualified Practitioner who is not a Member and has not applied for Medical Staff membership when the special skills of that Practitioner would be beneficial to a specific Hospital Patient(s)

who is under the care of the requesting Member and such skills are not readily available from a Member. Such temporary Clinical Privileges automatically terminate when the named Patient(s) is discharged from the Hospital.

5.4.2.3 Locum Tenens. The individuals listed in Section 5.4.1 may grant temporary Clinical Privileges to an appropriately licensed Practitioner whose services are needed at the Hospital on a locum tenens basis and who has not applied for Medical Staff membership. Temporary Clinical Privileges may be granted in such circumstances for no more than 120 consecutive Days.

5.4.3 Supervision. Practitioners granted temporary Clinical Privileges shall be subject to the supervision of the chair of the department to which assigned and shall comply with these Bylaws and other documents that apply to Members. Temporary Clinical Privileges may be summarily revoked by the CEO, the President of the Medical Staff or the department chair. Denial or termination of temporary Clinical Privileges does not give rise to Due Process rights.

5.5 EMERGENCY CLINICAL PRIVILEGES

In case of emergency, any Practitioner who holds Clinical Privileges and any Member is permitted to do everything possible within the scope of his license to save the life of the Patient or to save the Patient from serious harm, regardless of Clinical Privileges or Staff category. For the purpose of this section, an “emergency” is defined as a condition in which serious, permanent harm may result to the Patient or in which the life of the Patient is in immediate danger, and any delay in administering treatment might add to that danger.

5.6 DISASTER CLINICAL PRIVILEGES

In the event of a disaster requiring activation of the Hospital’s emergency management plan and exceeding the professional resources of the Hospital to meet immediate Patient needs, the appropriate incident commander (CEO/designee) handling the disaster upon recommendation by one of the following: the CEO/Designee or Medical Executive Committee Representative may grant temporary disaster Clinical Privileges to qualified volunteers in a manner consistent with the Hospital’s emergency management plan.

Disaster privileges may be granted to Practitioners upon receipt of a valid government-issued photo identification issued by a state or federal agency (e.g. driver’s license or passport) and at least one of the following:

1. Current hospital photo ID card that clearly identifies professional designation
2. Current medical license with primary source verification of the license
3. ID that certifies the individual is a member of a Disaster Medical Assistance Team (DMAT)
4. ID that certifies a state, federal, or municipal entity has granted the individual the authority to administer Patient care under emergency circumstances
5. Presentation by a current Hospital or Medical Staff Member who can vouch for the Practitioner's identity.

Additionally, if possible, the Practitioner will be asked to provide information about other hospital affiliations and malpractice liability coverage.

Primary Source Verification of the above information should be obtained by the Medical Staff office within 72 hours after the Practitioner presents himself or herself to the Hospital and the National Practitioner Data Bank will be queried (if possible). However, if it is not possible to verify the information provided by the Practitioner, disaster privileges may still be issued at the discretion of the individual responsible for granting such privileges. A record of this information should be retained with the disaster privileges form. Copies of the form shall be distributed, either via electronic mail or hand-delivered (or information regarding the Practitioner shall be communicated in person if necessary) to all Hospital departments involved in the disaster/emergency as soon as possible.

Once granted disaster privileges, the Practitioner shall be assigned to a department of the Medical Staff, and to a Member with similar privileges to whom the Practitioner shall report for assignment for the treatment of Patients and who shall supervise the Practitioner during the emergency appointment period. Emergency privileges shall be specialty-specific (within the Practitioner's scope of practice).

When the emergency situation no longer exists, as determined by the incident commander, these disaster privileges terminate unless the Practitioner is available, willing, and qualified according to the Medical Staff Bylaws to provide continuing care. In this case, the Medical Staff Policy on temporary privileges will be invoked.

5.7 CONDITIONS TO CLINICAL PRIVILEGES

The provisions of this Section are express conditions to any Practitioner's application for, and exercise of, Clinical Privileges at the Hospital. By applying for Clinical Privileges and/or Medical Staff membership, the Practitioner accepts these conditions with respect to the processing and consideration of his application, whether or not membership/Clinical Privileges are granted, and with respect to Clinical Privileges/membership granted.

5.7.1 Release of Liability and Immunity. The Practitioner extends absolute immunity to, and waives any claim, present or future, against, the Hospital, the Medical Staff, and/or any of their/its representatives, relative to any action, communication or recommendation taken, made or requested, concerning the Practitioner's qualifications or conduct and evaluation thereof, whether in connection with the Practitioner's initial application for Clinical Privileges/Medical Staff membership or any subsequent activities relating to the Practitioner's Clinical Privileges/Medical Staff membership. This waiver and release of claims also extends to third parties that furnish information described in this Section, including otherwise privileged or confidential information, to the Medical Staff, the Hospital, or their representatives.

5.7.2 Authorize Communication. The Practitioner authorizes the representatives of the Medical Staff and Hospital to consult with other hospitals, medical associations, licensing boards and other organizations and individuals who may have

information bearing on the Practitioner's character, conduct, ethics, physical and mental health, competence and other qualifications (collectively, "Qualifications"), and authorizes said individuals and organizations to provide information to representatives of the Medical Staff and Hospital.

5.7.3 Authorize Document Inspection. The Practitioner consents to representatives of the Medical Staff and Hospital inspecting all records and documents relevant to an evaluation of the Practitioner's Qualifications.

5.7.4 Authorize Release of Information. The Practitioner authorizes representatives of the Hospital and the Medical Staff to provide other hospitals, medical associations, licensing boards, and other organizations and individuals concerned with provider performance and the quality of Patient care with any relevant information regarding the Practitioner.

5.7.5 Confidentiality of Professional Practice Review Material. The Practitioner agrees to maintain the confidentiality of all Hospital professional practice review/peer review materials.

5.7.6 Health Status. The Practitioner agrees to submit to mental and physical examination and testing (including drug, alcohol and infection screens) by a health professional or at a facility satisfactory to the Medical Executive Committee, Credentials Committee, or Board, if requested in order to determine that the Practitioner's current physical or mental health does not threaten or interfere with his ability to practice safely. The results of such examination and testing shall be submitted directly to the body that requested them or the body's designee.

VI. CORRECTIVE ACTION

6.1 GROUNDS FOR REQUEST

Any officer of the Medical Staff, the chair of any department or committee of the Medical Staff, the Chief Executive Officer, any members of the Medical Executive Committee, or the Board of Trustees may request corrective action with respect to a Practitioner with Clinical Privileges based on reasonable grounds including, but not limited to, any of the following:

6.1.1 It appears the Practitioner no longer possesses the qualifications for Medical Staff membership or for the Clinical Privileges held.

6.1.2 Personal activity or professional conduct which is, or is likely to be, detrimental to Patient safety or to delivery of Patient care, or disruptive to Hospital operations.

6.1.3 Unethical professional practice in or outside of the Hospital.

6.1.4 Conduct that constitutes sexual harassment or morally offensive conduct toward any Medical Staff Member, Practitioner who holds Clinical Privileges, Hospital personnel, Patient, or Hospital visitor.

6.1.5 Violation of the Rules.

6.1.6 Conduct that indicates unwillingness or inability to work harmoniously with Medical Staff Members, other Practitioners who hold Clinical Privileges, Hospital personnel, or Patients.

6.2 FORM OF REQUEST

All requests for corrective action shall be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific activity or conduct which constitutes the grounds for the request. If a member of the Medical Executive Committee is the subject of a request for corrective action, that member shall not participate in MEC discussions or action relating to the request. Complaints regarding a Practitioner that are lodged by anyone other than the individuals listed in Section 6.1 shall be directed to the chair of the department to which the Practitioner is assigned.

6.3 NOTICE OF REQUEST

The Chief Executive Officer shall be notified in writing of all requests for corrective action received by the Medical Executive Committee and shall be kept fully informed of all action taken in conjunction therewith.

6.4 INVESTIGATION

The Medical Executive Committee may designate an individual or an ad hoc committee (from among its members or not) to investigate the grounds for a request for corrective action, if deemed necessary or appropriate by the Medical Executive Committee. The designated person or committee shall promptly investigate the matter (which may, but is not required to, include an interview with the affected Practitioner) and, within 30 Days after receipt of the assignment, shall forward a written report of its/his findings to the Medical Executive Committee. If the affected Practitioner is interviewed, the interview shall be informal; such an interview does not constitute a hearing and therefore none of the procedural rules relating to Due Process (including the presence of an attorney) shall apply.

6.5 OPTIONAL MEDICAL EXECUTIVE COMMITTEE INTERVIEW OF PRACTITIONER

At any point after it receives a corrective action request, the Medical Executive Committee may, but is not required, to interview the affected Practitioner. As described in Section 6.4, any such interview does not constitute a Due Process hearing.

6.6 MEDICAL EXECUTIVE COMMITTEE'S ACTION ON REQUEST

As soon as practical after receiving the corrective action request or (if an investigation was performed) after receipt of the investigating party's report, the Medical Executive Committee shall act on the request. The Medical Executive Committee's response to a corrective action request may include, without limitation:

6.6.1 Reject the request for corrective action or require further investigation.

6.6.2 Issue a written warning that future corrective action will be taken if the affected Practitioner's behavior does not conform to the standards stated in the warning.

6.6.3 Issue a written reprimand stating the MEC's disapproval of the affected Practitioner's behavior, and directing that the behavior cease immediately.

6.6.4 Require proctoring or consultation (if the affected Practitioner is not required to obtain consent of the consultant or proctor before the Practitioner may provide Patient care).

6.6.5 Require education to improve the affected Practitioner's knowledge, skills or ability in clinical subjects or in non-clinical subjects (such as anger management), which does not affect current Clinical Privileges.

6.6.6 Require a health assessment of the affected Practitioner by a health professional or at a facility selected by the Medical Executive Committee and under such conditions (including reports to the MEC or its designee) as the MEC may establish, and/or require the affected Practitioner to undergo appropriate treatment.

6.6.7 Recommend to the Board of Trustees:

6.6.7.1 Reduction, limitation, suspension, or revocation of Clinical Privileges;

6.6.7.2 Suspension or revocation of Staff appointment;

6.6.7.3 Any other form of discipline that materially limits the Practitioner's right to provide direct Patient care as previously authorized (such as proctoring or consultation in which consent of the proctor or consultant is required before Patient care may be provided).

6.7 REPORT TO THE BOARD

6.7.1 All Medical Executive Committee actions relating to a corrective action request shall be reported promptly to the Board.

6.7.2 If the Medical Executive Committee recommends any of the actions specified in Section 6.6.7, the Board will not act on the recommendation until the affected

Practitioner has either waived Due Process or Due Process has been provided. The Board may then adopt, modify, or reject the Medical Executive Committee's recommendation.

6.7.3 In addition to considering and acting upon recommendations of the Medical Executive Committee regarding corrective action, the Board may, at any time, respond to a corrective action request by imposing corrective action against the Practitioner, subject to the Practitioner's right, if applicable, to Due Process.

6.8 MONITORING PRACTITIONER'S COMPLIANCE

If the Medical Executive Committee's or the Board's response to a corrective action request entails proctoring, consultation, continuing education or other remedies that require subsequent evaluation to determine the affected Practitioner's compliance, competence, or improvement, the Medical Executive Committee or Board, as applicable, shall designate an individual to monitor the affected Practitioner's compliance and to report to the Medical Executive Committee or Board regarding the Practitioner's progress or the lack of progress, until the matter is resolved.

VII. SUMMARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

7.1 IMPOSITION

The following individuals and bodies have the authority to suspend or restrict summarily all or any portion of the Clinical Privileges of a Practitioner whenever failure to take immediate action may result in an imminent danger to the mental or physical health or safety of any individual: (a) any two of the following individuals: President of the Medical Staff, the chair of the department in which the Practitioner holds Clinical Privileges, and the Chief Medical Officer, (b) the Executive Committee of the Medical Staff, or (c) the Executive Committee of the Board of Trustees. Summary suspension is effective immediately upon imposition. The President of the Medical Staff, the Chief Executive Officer, or the chairperson of the Board shall promptly notify the suspended Practitioner of the suspension by Special Notice.

7.2 INTERIM NATURE

A summary suspension shall be deemed an interim precautionary step in a professional review activity until it has been reviewed by the Medical Executive Committee pursuant to Section 7.3.

7.3 MEDICAL EXECUTIVE COMMITTEE REVIEW

Within seven (7) business Days after the affected Practitioner receives notice of the summary suspension, the Practitioner may make a written request to the President of the Medical Staff that the Medical Executive Committee review the suspension at a special meeting. If the suspended Practitioner makes a timely request, the Medical Executive Committee will hold a special meeting to review the suspension within seven (7) business

Days from receipt of the Practitioner's request. If the affected Practitioner does not make a timely request, the Medical Executive Committee shall review the suspension at its next regular meeting. The Medical Executive Committee's review of the suspension shall be an informal proceeding and shall not be deemed a hearing and therefore none of the Due Process rights (including presence of an attorney) shall apply. The suspended Practitioner will be invited to present his point of view to the Medical Executive Committee at the meeting provided for in this Section. The Medical Executive Committee may recommend modification, continuation or termination of the summary suspension and shall recommend the future status of the Practitioner's Medical Staff membership/Clinical Privileges (for example, reinstate after suspension of a specified duration, or terminate Medical Staff membership/Clinical Privileges).

7.4 FAVORABLE RECOMMENDATION

If the Medical Executive Committee, acting pursuant to Section 7.3, recommends termination of the suspension and a disposition of the matter which does not trigger Due Process, such recommendation shall be transmitted immediately, together with all supporting documentation, to the Board. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision by the Board; provided, however, that the suspension shall be terminated (as recommended by the Medical Executive Committee) unless the Board makes a final decision to the contrary within fifteen (15) Days after the Board chair receives the Medical Executive Committee's recommendation.

7.5 UNFAVORABLE RECOMMENDATION

If the Medical Executive Committee, acting pursuant to Section 7.3, recommends continuation of the suspension and/or a disposition of the matter that triggers Due Process, the Practitioner shall be entitled to Due Process. The terms of the summary suspension shall remain in effect pending a final decision by the Board regarding the suspension and the future status of the Practitioner's Medical Staff membership/Clinical Privileges.

7.6 CARE OF PATIENTS

Immediately upon imposition of a summary suspension, the President of the Medical Staff, Chief Executive Officer, and Chief Medical Officer shall have authority to provide for alternative medical coverage for Patients of the suspended Practitioner who are still in the Hospital. The wishes of the Patients shall be considered, as feasible, in the selection of an alternative Practitioner.

VIII. INVESTIGATIVE SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

8.1 IMPOSITION

The following individuals and bodies have the authority to suspend or restrict all or any portion of the Clinical Privileges of a Practitioner for up to 14 Days pursuant to this Article VIII: (a) any two of the following individuals: President of the Medical Staff, the chair of the department in which the Practitioner holds Clinical Privileges, and the Chief Medical Officer, (b) the Executive Committee of the Medical Staff, or (c) the Executive Committee of the Board of Trustees. An investigative suspension may be imposed if two of the individuals or a body listed in this Section conclude that grounds may exist for imposing summary suspension under Article VII, but additional time and investigation is needed to determine the relevant facts (for example, to reconcile conflicting accounts of a key event), or to obtain access to the expertise needed to determine whether summary suspension is warranted. An investigative suspension is effective immediately upon imposition. The President of the Medical Staff, the Chief Executive Officer, or the chairperson of the Board shall promptly notify the suspended Practitioner of the suspension by Special Notice.

8.2 INTERIM NATURE

An investigative suspension shall be deemed an interim precautionary step in a professional review activity, and does not constitute disciplinary action or a determination regarding the affected Practitioner's competence. An investigative suspension ends (a) 14 Days after it is imposed or (b) when lifted by the individuals or body that imposed it, whichever occurs first.

8.3 CARE OF PATIENTS

Immediately upon imposition of an investigative suspension, the President of the Medical Staff, Chief Executive Officer, and Chief Medical Officer shall have authority to provide for alternative medical coverage for Patients of the suspended Practitioner who are still in the Hospital. The wishes of the Patients shall be considered, as feasible, in the selection of an alternative Practitioner.

IX. AUTOMATIC SUSPENSION/TERMINATION OF CLINICAL PRIVILEGES/MEMBERSHIP

If a Practitioner's Medical Staff membership or Clinical Privileges are automatically suspended or terminated, the Medical Staff Office shall notify the Practitioner of the suspension or termination in writing, after notifying the President of the Medical Staff. The following events shall result in automatic suspension or termination of a Practitioner's Medical Staff membership or Clinical Privileges, as specified, without right to Due Process:

9.1 PROFESSIONAL LICENSE

A Practitioner whose license to practice a health profession in the State of Iowa is suspended, restricted or lapsed shall automatically be suspended from practicing in the Hospital. If a Practitioner's health profession license in the State of Iowa is revoked or otherwise terminated, or is suspended, restricted or lapsed for more than sixty (60)

consecutive days, the Practitioner's Medical Staff membership and Clinical Privileges shall terminate automatically.

9.2 DRUG ENFORCEMENT ADMINISTRATION (DEA) REGISTRATION OR STATE CONTROLLED SUBSTANCES LICENSE

A Practitioner whose DEA registration or State of Iowa controlled substances license is revoked, suspended, restricted or lapsed shall automatically be divested of the right to prescribe medications covered by such registration/license. As soon as practical after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the DEA registration or state controlled substances license was revoked, suspended, restricted or lapsed. The Medical Executive Committee shall then take such further action, if any, pursuant to Article VI or VII, as the Medical Executive Committee determines appropriate.

9.3 MEDICAL RECORDS

In accordance with the Rules, an automatic suspension of a Practitioner's Clinical Privileges shall be imposed for failure to complete medical records within the periods prescribed in the Rules.

9.4 PROFESSIONAL LIABILITY INSURANCE

A Practitioner who fails to maintain professional liability insurance as required by the Board of Trustees shall be automatically suspended from practicing in the Hospital. If the Practitioner fails to provide the Hospital with adequate evidence of the required insurance within ninety (90) Days after being suspended, the Practitioner's Medical Staff membership and Clinical Privileges shall terminate automatically.

9.5 FEDERAL PROGRAM EXCLUSION

Exclusion of a Practitioner from a federal health care program shall cause an automatic termination of the Practitioner's Medical Staff membership and Clinical Privileges. The terms of this Section do not apply to a voluntary decision by a Practitioner not to participate in federal health care program(s).

9.6 DUES

If a Medical Staff Member fails to pay Medical Staff dues within ninety (90) days after the due date, the Member's Clinical Privileges shall be suspended automatically until dues are paid in full.

9.7 LEAVE OF ABSENCE

Failure to submit a timely request for reinstatement from a leave of absence or failure to provide a summary of activities during a leave of absence or other information requested or required will result in automatic termination of Medical Staff membership and Clinical Privileges as provided in Section 2.6.

9.8 REAPPOINTMENT

A Practitioner who fails to file a timely application for reappointment to the Medical Staff or renewal of Clinical Privileges shall automatically cease to be a Medical Staff Member and cease to hold Clinical Privileges upon expiration of the Practitioner's term of appointment.

9.9 ADVANCED PRACTICE PROFESSIONALS

The Clinical Privileges of an APP are subject to automatic termination as provided in Section 3.6.4.

9.10 DOCUMENTATION OF CREDENTIALS

A Practitioner who fails to provide the Hospital with written evidence of current and continuous professional license and professional liability insurance, within thirty (30) Days of written request therefor, shall automatically be suspended from practicing at the Hospital until such documentation is furnished. If a Practitioner fails to provide the Hospital with written evidence of current and continuous DEA registration and state controlled substances license (if applicable), within thirty (30) Days of written request therefor, the Practitioner's right to prescribe medications covered by such registration/license shall automatically be suspended until such documentation is furnished.

9.11 HEALTH EVALUATION

A Practitioner who fails to submit to a physical or mental health evaluation within thirty (30) Days of a written request therefor by the Board based on evidence of need for the evaluation supplied to the Board by the Medical Executive Committee, shall be automatically suspended from practicing at the Hospital until the evaluation occurs. If the Practitioner fails to submit to the evaluation and furnish the Hospital with the results thereof within thirty (30) Days after being suspended, the Practitioner's Medical Staff membership and Clinical Privileges shall terminate automatically.

9.12 COMMUNICABLE DISEASE TEST RESULTS

A Practitioner who fails to provide satisfactory evidence of communicable disease test results as required by Hospital policy, within thirty (30) Days of written request therefor, shall be automatically suspended from practicing at the Hospital until such documentation is furnished. If the Practitioner fails to provide the Hospital with satisfactory evidence of test results within ninety (90) Days after being suspended, the Practitioner's Medical Staff membership and Clinical Privileges shall terminate automatically.

9.13 REPORTS OF ADVERSE EVENTS

Within thirty (30) Days after any of the following events occurs with respect to a Practitioner, that Practitioner shall report the matter in writing to the President of the

Medical Staff: (a) the Practitioner is convicted of (or pleads guilty or no contest to) a felony, (b) disciplinary action is imposed on the Practitioner by a licensed health facility, or (c) the Practitioner resigns or limits clinical privileges at a licensed health facility while under investigation or in order to avoid an investigation or proceedings. A Practitioner's Medical Staff membership and Clinical Privileges shall be suspended automatically if the Medical Executive Committee or Board determines that the Practitioner failed to make a report that is required by this Section. If summary suspension is not imposed within thirty (30) Days after an automatic suspension is imposed pursuant to this Section 9.13, the automatic suspension shall expire at the end of that 30 -Day period.

X. HEARING AND APPELLATE REVIEW PROCESS - MEDICAL STAFF MEMBERS AND APPLICANTS

10.1 DUE PROCESS

The Due Process rights of Medical Staff Members and of applicants for Medical Staff membership are governed by this Article X.

10.2 RIGHT TO A HEARING

10.2.1 Hearing. The affected Practitioner will be entitled to a hearing if (a) the Medical Executive Committee recommends any of the following actions or (b) the Board of Trustees decides to take any of the following actions (and the Board's action was not preceded by a recommendation by the Medical Executive Committee to take one of the following actions):

10.2.1.1 denial of Medical Staff membership;

10.2.1.2 denial of Medical Staff reappointment;

10.2.1.3 denial of requested initial or renewed Clinical Privileges;

10.2.1.4 denial of requested increased Clinical Privileges;

10.2.1.5 suspension or revocation of Medical Staff membership;

10.2.1.6 reduction, limitation, suspension or revocation of Clinical Privileges;

10.2.1.7 denial of request for reinstatement from a leave of absence; or

10.2.1.8 other material limitation of the right to provide direct Patient care as previously authorized (such as requiring proctoring or consultation, if the affected Practitioner is required to obtain consent of the proctor or consultant before Patient care may be provided).

10.2.2 No Right to Hearing. The affected Practitioner will not be entitled to a hearing as a result of a recommendation or action that is not listed in Section 10.2.1, including the following matters:

10.2.2.1 voluntary resignation of Clinical Privilege(s) or Medical Staff membership, including expiration and failure to file timely and complete application for reappointment/renewal of Clinical Privileges;

10.2.2.2 issuance of a written warning or a letter of reprimand;

10.2.2.3 imposition of a consultation or proctoring requirement, if the affected Practitioner is not required to obtain consent of the consultant/proctor before Patient care may be provided;

10.2.2.4 imposition of an investigative suspension or restriction of Clinical Privileges pursuant to Article VIII of these Bylaws;

10.2.2.5 imposition of automatic suspension or termination pursuant to Article IX of these Bylaws;

10.2.2.6 denial of a request for, or termination of, temporary Clinical Privileges;

10.2.2.7 denial of a request for, or imposition of conditions or limitations on, a leave of absence;

10.2.2.8 mandated education, which does not affect current Clinical Privileges;

10.2.2.9 any action or recommendation (including those listed in Section 10.2.1) based on the Practitioner's failure to meet the written minimum objective criteria for the Clinical Privileges or Medical Staff status at issue including failure to perform the minimum required Activity Units or failure to obtain or maintain Board Certification in accordance with Bylaws section 2.4.12; or

10.2.2.10 requiring a health assessment, report and/or treatment, as described in Section 6.6.6.

10.2.3 Exhaustion of Administrative Remedies. A Practitioner must exhaust Due Process rights before filing a lawsuit relating to any matter listed in Section 10.2.1.

10.3 PRE-HEARING PHASE

10.3.1 Notice of Hearing Rights

10.3.1.1 The Chief Executive Officer shall notify the Practitioner by Special Notice of a recommendation or action which entitles the Practitioner to Due Process.

10.3.1.2 The notice referred to in Section 10.3.1.1 shall state the following:

10.3.1.2.1 The adverse recommendation or action.

10.3.1.2.2 The reason(s) for the adverse recommendation or action.

10.3.1.2.3 The Practitioner's right to request a hearing.

10.3.1.2.4 A summary of the Practitioner's hearing rights.

10.3.1.2.5 A time limit of thirty (30) Days from the date of the Practitioner's receipt of the notice within which the Practitioner may submit a written request for a hearing to the Chief Executive Officer. The Practitioner's request for a hearing shall state whether the Practitioner will be represented at the hearing by either a Member of the Medical Staff or an attorney. A Practitioner who is subject to a summary suspension or whose term of appointment is likely to expire during Due Process, may request an early hearing as described in Section 10.3.2.1.

10.3.1.3 If the Chief Executive Officer does not receive a written request for a hearing from the Practitioner within the 30-Day deadline, the Practitioner waives all right to Due Process.

10.3.2 Notice of Scheduled Hearing; Witness Lists.

10.3.2.1 Within sixty (60) Days after receipt of a timely request for a hearing, the Chief Executive Officer shall, after consultation with President of the Medical Staff or the Board, notify the Appellant by Special Notice of the date, time and place of the hearing. Best efforts will be made to issue this notice of a scheduled hearing in fewer than sixty (60) Days if the Appellant requested an early hearing pursuant to Section 10.3.1.2.5.

10.3.2.2 The notice of the hearing shall be delivered at least thirty (30) Days in advance of the scheduled hearing date (unless this time limit is mutually waived) and shall include a list of the witnesses, if any, expected to testify at the hearing on behalf of the Hospital; the Hospital shall supplement the list with a written list of the names of additional witnesses as they are determined.

10.3.2.3 Not less than fourteen (14) Days before the hearing, the Appellant shall furnish to the Chief Executive Officer a written list of the names of the individuals expected to testify at the hearing on behalf of the Appellant; the Appellant shall supplement the list with a written list of the names of additional witnesses as they are determined.

10.3.2.4 Any witness who was not identified in writing to the other party at least seven (7) Days before the date of testimony may testify only if the presiding officer determines there was good cause for not furnishing earlier notice.

10.3.3 Composition and Appointment of Hearing Committee.

10.3.3.1 When a hearing is triggered by an adverse recommendation of the Medical Executive Committee, the President of the Medical Staff and the Chief Medical Officer, acting on behalf of the Hospital, shall jointly appoint a committee of not fewer than three (3) Members of the Medical Staff (the “Hearing Committee”). One of the members shall be designated as chair.

10.3.3.2 When a hearing is triggered by an adverse decision of the Board of Trustees, the Board Chair shall appoint a committee of not fewer than three (3) members (the “Hearing Committee”). One of the members shall be designated as chair.

10.3.3.3 No member of a Hearing Committee may be in direct economic competition with the Appellant or be a professional or business associate or family member of the Appellant. In addition, no member of a Hearing Committee may have been involved in initiating or investigating the underlying matter, or have been a member of any ad hoc committee whose findings are before the Hearing Committee.

10.3.4 Hearing Officer. The individuals who appoint the Hearing Committee may, with the concurrence of the Chief Executive Officer, appoint a hearing officer, who may not be legal counsel to the Hospital, to preside at the hearing. The Hearing Officer may not act as a prosecuting officer, or as an advocate for the Board of Trustees, the Medical Executive Committee or the Appellant. The Hearing Officer will, at the request of the Hearing Committee, participate in the deliberations of the Hearing Committee, serve as a legal advisor to it, and assist in drafting the Hearing Committee's report, but shall not be entitled to vote. If a hearing officer is not appointed, the Chair of the Hearing Committee shall preside.

10.3.5 Pre-Hearing Conference.

10.3.5.1 Prior to or at the beginning of any hearing the presiding officer may, in his discretion, require the representatives of the parties to participate in a conference to consider:

10.3.5.1.1 The framing and simplification of issues to be presented at the hearing;

10.3.5.1.2 Admission of facts or documents which will avoid unnecessary hearing testimony and proof;

10.3.5.1.3 Limitation by the presiding officer of the number of witnesses to be called by the parties in order to reduce repetitive or irrelevant testimony;

10.3.5.1.4 Such other matters as the presiding officer determines may aid in the expeditious disposition of the matters before the Hearing Committee.

10.3.5.2 The pre-hearing conference may be held by phone. The presiding officer may submit a summary of the decisions reached at the conference to the Hearing Committee and such summary will be used to control the subsequent course of the hearing.

10.3.6 Documents. The Appellant shall be entitled, upon request, to access to the information on which the Medical Executive Committee or Board, as applicable, relied in making the adverse recommendation or action that is the subject of the hearing, provided the Appellant and Appellant's attorney, if any, shall agree in writing to preserve the confidentiality of any professional practice review materials to which they are given access. There are no other discovery rights.

10.4 HEARING PHASE

10.4.1 Preliminary Rules.

10.4.1.1 At least a majority (minimum of at least three (3) Medical Staff Members) of the members of the Hearing Committee shall be present when the hearing takes place.

10.4.1.2 An accurate record of the hearing shall be kept by means of a court reporter or an electronic recording unit, as selected by the Hearing Committee. Upon request, the Appellant shall be entitled to a copy of the hearing record upon payment of any reasonable charge for preparation thereof.

10.4.1.3 Postponement of a hearing beyond the time set forth in these Bylaws may be granted by the Hearing Committee, but only for a good reason, and in the sole discretion of the Hearing Committee.

10.4.2 Presence of Appellant.

10.4.2.1 The personal presence of the Appellant shall be required.

10.4.2.2 An Appellant who fails, without good cause, to appear at a hearing waives his rights to Due Process.

10.4.3 Representation.

10.4.3.1 If the hearing is triggered by an adverse recommendation of the Medical Executive Committee, the President of the Medical Staff shall appoint a Medical Staff Member and/or an attorney to represent the Medical Executive Committee at the hearing.

10.4.3.2 If the hearing is triggered by an adverse decision of the Board of Trustees, the Board Chair shall appoint one of its members and/or an attorney to represent the Board of Trustees at the hearing.

10.4.3.3 The Appellant shall be entitled to be represented at the hearing by a member of the Medical Staff or an attorney, if the Appellant states his intent to be so represented in the request for a hearing.

10.4.4 Conduct of Hearing.

10.4.4.1 The presiding officer shall preside over the hearing, determine the order of procedure during the hearing, determine what evidence is admissible, ensure that all participants in the hearing have a reasonable opportunity to present oral and documentary evidence, rule on any issues that arise, set deadlines for the submission of briefs or other documentation, maintain decorum, ensure that all parties present their positions without delay, and ensure that no party abuses its privileges under this Article. The presiding officer may limit the number of witnesses and/or duration of testimony, especially character witnesses or evidence that is repetitive.

10.4.4.2 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule that might make the evidence inadmissible over objection in a civil or criminal action.

10.4.4.3 The parties to the hearing shall have the following rights:

10.4.4.3.1 To call and examine witnesses; however, neither party has the authority to compel witnesses to appear;

10.4.4.3.2 To introduce written evidence;

10.4.4.3.3 To cross-examine any witness on any relevant matter;

10.4.4.3.4 To challenge any witness and to rebut any evidence.

10.4.4.4 If the Appellant does not otherwise testify, the Appellant may be called and examined as if under cross-examination.

10.4.4.5 Members of the Hearing Committee may question witnesses. Witnesses may volunteer information which the Hearing Committee determines to be relevant, even if not elicited by a specific question posed by the Hearing Committee or by a party.

10.4.4.6 Each party shall present any objections to procedures to the presiding officer as soon as possible, so that they may be timely addressed.

10.4.4.7 The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of its action. The Appellant shall have the burden of proving that there was no reasonable basis for the adverse recommendation/action.

10.4.4.8 Each party may, at the close of the hearing, submit a statement concerning any relevant issues of procedure or of fact, and such statements shall become part of the hearing record. The Hearing Committee may require such statements to be filed within a specified time after the close of the hearing and may limit the length thereof.

10.4.5 Recess of Hearing. The Hearing Committee may, at its discretion, recess the hearing and reconvene the same for the convenience of the participants, for the purpose of obtaining new or additional evidence or consultation, or for any other appropriate reason.

10.5 POST-HEARING PHASE

10.5.1 Decision of Hearing Committee.

10.5.1.1 The Hearing Committee shall deliberate outside the presence of the parties to the hearing. No member of the Hearing Committee may vote by proxy. Within thirty (30) Days after the closing of the hearing, the Hearing Committee shall make a written report containing its recommendations and the basis therefor, and shall forward the report, together with the complete hearing record and all written evidence and exhibits, to the body whose action triggered the hearing (either the Medical Executive Committee or the Board of Trustees). The Chief Executive Officer shall send a copy of the Hearing Committee's report to the Appellant by Special Notice.

10.5.1.2 The Hearing Committee's report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or adverse decision of the Board of Trustees.

10.5.1.3 At its next regularly scheduled meeting, but not more than thirty (30) Days after receiving the Hearing Committee's written report, the Medical Executive Committee or the Board of Trustees, whichever initiated the hearing, shall affirm, modify or reverse its original recommendation/action.

10.5.2 Notice of Post-Hearing Recommendation.

10.5.2.1 Medical Executive Committee-Initiated Hearing. Within seven (7) Days after the Medical Executive Committee makes its post-hearing recommendation, the Chief Executive Officer shall forward the recommendation, together with all supporting documentation, to the Board of Trustees for its decision and shall send a copy of the post-hearing recommendation to the Appellant by Special Notice.

10.5.2.1.1 At its next regularly scheduled meeting, the Board of Trustees shall elect one of the following options:

10.5.2.1.1.1 Concur with favorable Medical Executive Committee recommendation, in which case the Board of Trustees' decision is final.

10.5.2.1.1.2 Overrule unfavorable Medical Executive Committee recommendation, in which case the Board of Trustees' decision is final.

10.5.2.1.1.3 Overrule favorable Medical Executive Committee recommendation, in which case the Appellant has the right to request an Appellate Review pursuant to Section 10.6.

10.5.2.1.1.4 Concur with unfavorable Medical Executive Committee recommendation (including a Board decision to impose a form of discipline listed in Section 10.2.1 different from that recommended by the Medical Executive Committee), in which case the Appellant has the right to request an Appellate Review pursuant to Section 10.6.

10.5.2.1.2 The Chief Executive Officer shall promptly notify the Appellant by Special Notice of the Board of Trustees' decision and, if applicable, the Appellant's right to request an Appellate Review pursuant to Section 10.6.

10.5.2.2 Board of Trustees-Initiated Hearing.

10.5.2.2.1 When the Board of Trustees' post-hearing decision is favorable to the Appellant, the Board of Trustees' decision is final. The Chief Executive Officer shall promptly notify the Appellant of the favorable decision by Special Notice.

10.5.2.2.2 When the Board of Trustees' post-hearing decision is unfavorable to the Appellant, the Chief Executive Officer shall promptly notify the Appellant by Special Notice of the adverse decision and the Appellant's right to request an Appellate Review pursuant to Section 10.6.

10.5.2.3 "Favorable/Unfavorable." For purposes of this Section 10.5.2, a recommendation or action is "unfavorable" if it entails any of the appealable matters listed in Section 10.2.1, and is "favorable" if it does not entail any of the appealable matters listed in Section 10.2.1.

10.6 APPELLATE REVIEW

10.6.1 Appeal to the Board of Trustees.

10.6.1.1 An Appellant who is entitled to an Appellate Review shall have fifteen (15) Days following receipt of the Special Notice sent pursuant to Section 10.5.2.1.2 or 10.5.2.2.2 in which to submit a written request for Appellate Review to the Chief Executive Officer by means of Special Notice. If the Appellant wishes to make an oral statement to the Appellate Review Committee, the Appellant's request for Appellate Review must include a request to make an oral statement.

10.6.1.2 If the Chief Executive Officer does not receive a written request for Appellate Review from the Appellant within the 15-Day deadline, the Appellant waives

the right to Appellate Review and the adverse recommendation or decision shall remain in effect.

10.6.1.3 Within fifteen (15) Days after receipt of a written request for an Appellate Review, the Board of Trustees shall schedule a date, time and place for the Review and notify the Appellant of same via Special Notice. The Appellate Review shall be held within sixty (60) Days after the date the Appellant's request for Appellate Review is received. The Appellant shall have the burden of proving that there was no reasonable basis for the adverse recommendation/action which is the subject of the Appellate Review.

10.6.1.4 The Appellate Review shall be conducted by an ad hoc committee of the Board of Trustees, composed of not fewer than three (3) of its members (the "Appellate Review Committee"). No member of the Appellate Review Committee may be in direct economic competition with the Appellant or be a professional or business associate or family member of the Appellant. In addition, no member of the Appellate Review Committee may have been involved in initiating or investigating the underlying matter, or have been a member of any ad hoc or hearing committee whose findings are before the Appellate Review Committee.

10.6.1.5 The Appellant may, at least fifteen (15) Days prior to the scheduled date of the Appellate Review, submit a written statement regarding those factual and procedural matters with which the Appellant disagrees, and the reasons for such disagreement. Such written statement shall be submitted to the Chief Executive Officer by Special Notice. The Appellate Review Committee may limit the length of written statements.

10.6.1.6 The Appellate Review Committee, in its discretion, will determine whether oral statements will be allowed and, if so, the maximum duration of statements. If the Appellant requested an opportunity to make an oral statement and the Appellate Review Committee elects to permit oral statements, the Appellant or the Appellant's attorney shall be permitted to speak against the adverse decision and the Appellant and the Appellant's attorney shall answer questions from members of the Appellate Review Committee. The Board may also be represented by one of its members and/or an attorney to present its position and answer questions from any member of the Appellate Review Committee.

10.6.1.7 New or additional matters not raised during the original hearing or in the Hearing Committee report may be introduced at the Appellate Review only if the evidence is relevant and could not have been presented at the hearing. The Appellate Review Committee shall, in its sole discretion, determine whether such new matters will be accepted.

10.6.1.8 Within thirty (30) Days after the conclusion of the Appellate Review, the Appellate Review Committee shall make a written recommendation to the Board of Trustees.

10.6.2 Final Decision by the Board of Trustees. At its next regularly scheduled meeting, but not more than thirty (30) Days after receipt of the Appellate Review Committee's recommendation, the Board of Trustees shall consider the Appellate Review Committee's recommendation and make its final decision in the matter and shall send notice of its final decision to the Appellant by Special Notice and to the Medical Executive Committee.

10.6.3 Right to One Hearing and Appeal Only. No Practitioner shall be entitled to more than one hearing and one Appellate Review on any matter which may be the subject of a hearing/appeal, without regard to whether such matter is the subject of a recommendation or an action of the Medical Executive Committee or the Board of Trustees, or a combination of recommendations or actions of such bodies.

XI. HEARING AND APPELLATE REVIEW PROCESS – ADVANCED PRACTICE PROFESSIONALS AND APP APPLICANTS

11.1 DUE PROCESS

The Due Process rights of Advanced Practice Professionals and of applicants for APP status are governed by this Article XI.

11.2 RIGHT TO A HEARING

11.2.1 Hearing. The affected APP will be entitled to a hearing if (a) the Medical Executive Committee recommends any of the following actions or (b) the Board of Trustees decides to take any of the following actions (and the Board's action was not preceded by a recommendation by the Medical Executive Committee to take one of the following actions), but only if the recommendation or action is based on reason(s) directly related to the quality of Patient care:

11.2.1.1 denial of requested initial or renewed Clinical Privileges;

11.2.1.2 denial of requested increased Clinical Privileges;

11.2.1.3 reduction, limitation, suspension or revocation of Clinical Privileges;

11.2.1.4 denial of request for reinstatement from a leave of absence; or

11.2.1.5 other material limitation of the right to provide direct Patient care as previously authorized (such as requiring proctoring or consultation, if the affected APP is required to obtain consent of the proctor or consultant before Patient care may be provided).

11.2.2 No Right to Hearing. The affected APP will not be entitled to a hearing as a result of a recommendation or action that is not listed in Section 11.2.1, including the following matters:

11.2.2.1 voluntary resignation of Clinical Privilege(s) including expiration and failure to file timely application for renewal of Clinical Privileges;

11.2.2.2 issuance of a written warning or a letter of reprimand;

11.2.2.3 imposition of a consultation or proctoring requirement, if the affected APP is not required to obtain consent of the consultant/proctor before Patient care may be provided;

11.2.2.4 imposition of an investigative suspension or restriction of Clinical Privileges pursuant to Article VIII of these Bylaws;

11.2.2.5 imposition of automatic suspension or termination pursuant to Article IX of these Bylaws;

11.2.2.6 denial of a request for, or termination of, temporary Clinical Privileges;

11.2.2.7 denial of a request for, or imposition of conditions or limitations on, a leave of absence;

11.2.2.8 mandated education, which does not affect current Clinical Privileges;

11.2.2.9 any action or recommendation (including those listed in Section 11.2.1) that is not based on reason(s) directly related to quality of Patient care;

11.2.2.10 any action or recommendation (including those listed in Section 11.2.1) based on the APP's failure to meet the written minimum objective criteria for the Clinical Privileges at issue; or

11.2.2.11 requiring a health assessment, report and/or treatment, as described in Section 6.6.6.

11.2.3 Exhaustion of Administrative Remedies. An APP must exhaust the Due Process rights provided in these Bylaws before filing a lawsuit relating to any matter listed in Section 11.2.1.

11.3 PRE-HEARING PHASE

11.3.1 Notice of Hearing Rights.

11.3.1.1 The Chief Executive Officer shall notify the APP by Special Notice of a recommendation or action which entitles the APP to a hearing.

11.3.1.2 The notice referred to in Section 11.3.1.1 shall state the following:

11.3.1.2.1 The adverse recommendation or action.

11.3.1.2.2 The reason(s) for the adverse recommendation or action.

11.3.1.2.3 The APP's right to request a hearing.

11.3.1.2.4 A summary of the APP's hearing rights.

11.3.1.2.5 A time limit of fifteen (15) Days from the date of the APP's receipt of the notice within which the APP may submit a written request for a hearing to the Chief Executive Officer. An APP who is subject to a summary suspension or whose credentialing term is likely to expire during Due Process, may request an early hearing as described in Section 11.3.2.1.

11.3.1.3 If the Chief Executive Officer does not receive a written request for a hearing from the APP within the 15-Day deadline, the APP waives all rights to Due Process.

11.3.2 Notice of Scheduled Hearing.

11.3.2.1 Within thirty (30) Days after receipt of a timely request for a hearing, the Chief Executive Officer shall notify the Appellant by Special Notice of the date, time and place of the hearing. Best efforts will be made to issue this notice of a scheduled hearing in fewer than thirty (30) Days if the Appellant requested an early hearing pursuant to Section 11.3.1.2.5.

11.3.2.2 The notice of the hearing shall be delivered at least fifteen (15) Days in advance of the scheduled hearing date (unless this time limit is mutually waived).

11.3.3 Composition and Appointment of Hearing Committee.

11.3.3.1 When a hearing is triggered by an adverse recommendation of the Medical Executive Committee, the President Medical Staff, acting on behalf of the Hospital, shall appoint a Hearing Committee of not fewer than three (3) members. One of the members shall be designated as chair and shall preside at the hearing.

11.3.3.2 When a hearing is triggered by an adverse decision of the Board of Trustees, the Board Chair shall appoint a Hearing Committee of not fewer than three (3) members. One of the members shall be designated as chair and shall preside at the hearing.

11.3.3.3 No member of a Hearing Committee may be in direct economic competition with the Appellant or be a professional or business associate or family member of the Appellant.

11.3.4 Documents. The Appellant shall be entitled, upon request, to access to the information on which the Medical Executive Committee or Board, as applicable, relied in making the adverse recommendation or action that is the subject of the hearing, provided

the Appellant shall agree in writing to preserve the confidentiality of any professional practice review materials to which the Appellant is given access. There are no other discovery rights.

11.4 HEARING PHASE

11.4.1 Postponement. Postponement of a hearing beyond the time set forth in these Bylaws may be granted by the Hearing Committee, but only for a good reason, and in the sole discretion of the Hearing Committee.

11.4.2 Hearing Participants.

11.4.2.1 The personal presence of the Appellant shall be required. An Appellant who fails, without good cause, to appear at a hearing shall waive his rights to Due Process.

11.4.2.2 Attorneys will not attend the hearing.

11.4.3 Conduct of Hearing.

11.4.3.1 At the hearing, the Hearing Committee will provide the Appellant with an opportunity to respond orally to the reason(s) for the adverse recommendation or action and the Hearing Committee may question the Appellant. The Appellant may also submit written evidence to the Hearing Committee. Unless the Hearing Committee, within its discretion, agrees to an exception, only the Appellant will attend and present his views to the Hearing Committee.

11.4.3.2 The Hearing Committee may limit the duration of the hearing and the length of written evidence submitted to it. The hearing may be conducted informally and rules of evidence will not apply.

11.4.4 Recess of Hearing. The Hearing Committee may, at its discretion, recess the hearing and reconvene the same.

11.5 POST-HEARING PHASE

11.5.1 Decision of Hearing Committee.

11.5.1.1 The Hearing Committee shall deliberate outside the presence of the Appellant. Within thirty (30) Days after the hearing, the Hearing Committee shall state in writing its recommendations and the basis therefor, and shall forward its statement to the body whose action triggered the hearing (either the Medical Executive Committee or the Board of Trustees). The Chief Executive Officer shall send a copy of the Hearing Committee's statement to the Appellant.

11.5.1.2 The Hearing Committee may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or adverse decision of the Board of Trustees.

11.5.1.3 At its next regularly scheduled meeting, but not more than thirty (30) Days after receiving the Hearing Committee's written statement, the Medical Executive Committee or the Board of Trustees, whichever initiated the hearing, shall affirm, modify or reverse its original recommendation/action.

11.5.2 Notice of Post-Hearing Recommendation.

11.5.2.1 Medical Executive Committee-Initiated Hearing. Within seven (7) Days after the Medical Executive Committee makes its post-hearing recommendation, the Chief Executive Officer shall forward the recommendation, together with all supporting documentation, to the Board of Trustees for its decision and shall send a copy of the post-hearing recommendation to the Appellant.

11.5.2.1.1 At its next regularly scheduled meeting, the Board of Trustees shall elect one of the following options:

11.5.2.1.1.1 Concur with favorable Medical Executive Committee recommendation, in which case the Board of Trustees' decision is final.

11.5.2.1.1.2 Overrule unfavorable Medical Executive Committee recommendation, in which case the Board of Trustees' decision is final.

11.5.2.1.1.3 Overrule favorable Medical Executive Committee recommendation, in which case the Appellant has the right to request an Appellate Review.

11.5.2.1.1.4 Concur with unfavorable Medical Executive Committee recommendation (including a Board decision to impose a form of discipline listed in Section 11.2.1 different from that recommended by the Medical Executive Committee), in which case the Appellant has the right to request an Appellate Review.

11.5.2.1.2 The Chief Executive Officer shall promptly notify the Appellant by Special Notice of the Board of Trustees' decision and, if applicable, the Appellant's right to request an Appellate Review.

11.5.2.2 Board of Trustees-Initiated Hearing. The Board of Trustees' post-hearing decision is final. The Chief Executive Officer shall promptly notify the Appellant of the Board's decision.

11.5.2.3 "Favorable/Unfavorable." For purposes of this Section 11.5.2, a recommendation or action is "unfavorable" if it entails any of the appealable matters listed in Section 11.2.1, and is "favorable" if it does not entail any of the appealable matters listed in Section 11.2.1.

11.6 APPELLATE REVIEW

11.6.1 Appeal to the Board of Trustees.

11.6.1.1 An Appellant who is entitled to an Appellate Review shall have fifteen (15) Days following receipt of the Special Notice sent pursuant to Section 11.5.2.1.2 in which to submit to the Chief Executive Officer by means of Special Notice a written statement regarding those factual and procedural matters with which the Appellant disagrees, and the reasons for such disagreement. An Appellant who requests Appellate Review shall have the burden of proving that there was no reasonable basis for the adverse recommendation/action which is the subject of the Appellate Review.

11.6.1.2 If the Chief Executive Officer does not receive such a written statement from the Appellant within the 15-Day deadline, the Appellant waives the right to Appellate Review and the adverse recommendation or decision shall remain in effect.

11.6.2 Final Decision by the Board of Trustees. At its next regularly scheduled meeting, but not more than thirty (30) Days after receipt of a timely Appellate Review statement pursuant to Section 11.6.1, the Board of Trustees shall review the Appellant's written statement and make its final decision in the matter and shall send notice of its final decision to the Appellant by Special Notice and to the Medical Executive Committee.

11.6.3 Right to One Hearing and Appeal Only. No APP shall be entitled to more than one hearing and one Appellate Review on any matter which may be the subject of a hearing/appeal, without regard to whether such matter is the subject of a recommendation or an action of the Medical Executive Committee or the Board of Trustees, or a combination of recommendations or actions of such bodies.

XII. DEPARTMENTS

12.1 ORGANIZATION OF DEPARTMENTS

12.1.1 Departments. The Medical Staff shall be organized into departments. A department consists of Active Members who practice the same specialty or subspecialty, and are designated as a department by the Medical Executive Committee and the Board.

12.1.2 Modifications. When deemed appropriate, the Medical Executive Committee, subject to approval by the Board, may eliminate, subdivide, or combine departments after consultation with the affected department chair(s) and section chief(s).

12.1.3 Assignment. Each Practitioner who holds Clinical Privileges shall be assigned to one department and, if applicable, to a section. Qualified Practitioners may be Members of more than one Department.

12.2 DEPARTMENT OFFICERS

12.2.1 Offices. Each department shall have a chair and a vice chair.

12.2.2 Term of Office. Department officers shall serve for a two (2)-year term. An individual may not serve as chair of the same department for more than three (3) consecutive two (2)-year terms, except a vice chair who fills a vacancy in the office of chair may be elected as chair for up to three (3) additional consecutive two 2-year terms. These term limitations shall not apply to departments that are staffed by exclusive contract.

12.2.3 Officer Qualifications. Department officers shall be Active Members of the department and must maintain Active Staff membership. If the MEC determines that a department officer ceases to satisfy one of these qualifications for office, the office becomes vacant.

12.2.4 Conflicting Positions. An individual may not simultaneously serve in more than one elected Medical Staff or department office at the Hospital. An individual who serves as an elected Medical Staff or department officer, or member-at-large of the medical executive committee, of another hospital may not serve as a Medical Staff or department officer or at-large MEC member at the Hospital; unless there is an affiliation between MercyOne Siouxland Medical Center and the other Hospital.

12.2.5 Department Chair's Duties. The department chair shall be responsible to the President of the Medical Staff and the MEC for the functioning of the department, including performance of the following duties within the department:

12.2.5.1 Serve as a member of the MEC.

12.2.5.2 Call and preside at meetings of the department and vote at such meetings in the event of a tie.

12.2.5.3 Report to the MEC and the President regarding all department professional and administrative activities.

12.2.5.4 Oversee clinically related activities of the department.

12.2.5.5 Oversee administratively related activities of the department, unless otherwise provided by the Hospital.

12.2.5.6 Conduct ongoing evaluation of the professional performance of all Practitioners in the department who have Clinical Privileges.

12.2.5.7 Recommend to the MEC the criteria for Clinical Privileges that are relevant to the care provided in the department.

12.2.5.8 Make recommendations regarding Clinical Privileges and reappointment for each Member of the department and each APP assigned to the department.

12.2.5.9 Take appropriate action when important problems in Patient care or clinical performance or opportunities to improve care are identified.

12.2.5.10 Appoint such committees and their chairs as are necessary or appropriate to conduct department functions.

12.2.5.11 Assess and recommend to the relevant Hospital authority off-site sources for needed Patient care, treatment, and services not provided by the department or the Hospital.

12.2.5.12 Integrate the department into the primary functions of the Hospital.

12.2.5.13 Coordinate and integrate interdepartmental and intradepartmental services.

12.2.5.14 Develop and implement policies and procedures that guide and support the provision of care, treatment, and services in the department (subject to applicable approval requirements), and recommend to the MEC for approval any department policies and procedures with multi-department impact.

12.2.5.15 Recommend a sufficient number of qualified and competent Practitioners to provide care, treatment, and service.

12.2.5.16 Confirm that the Hospital maintains a process to determine the qualifications and competence of department personnel who are not licensed independent practitioners and who provide Patient care, treatment, and services.

12.2.5.17 Conduct continuous assessment and improvement of the quality of care, treatment, and services.

12.2.5.18 Maintain quality improvement programs, as appropriate.

12.2.5.19 Confirm that the Hospital provides for the orientation and continuing education of all persons in the department.

12.2.5.20 Recommend space and other resources needed by the department.

12.2.5.21 Implement the Medical Staff Bylaws and the Rules, and actions taken by the MEC.

12.2.5.22 Participate in activities relating to the accreditation and licensure of the Hospital that are relevant to the department.

12.2.5.23 Collaborate with the nursing staff on matters in which nursing and medical practice interrelate.

12.2.6 Vice Chair's Duties. The vice chair of each department shall perform such duties as are delegated to him by the chair of the department. He shall act with full authority and responsibility in the absence of the chair. The vice chair shall immediately

succeed to the office of chair for the remainder of the current term if the chair should resign or be removed.

12.2.6.1 Accept such responsibility as may from time to time be delegated by the chair of the department.

12.2.6.2 Make recommendations, consistent with those duties outlined in Section 12.2.5 of these Bylaws, to the department chair who in turn shall present such recommendations to the MEC.

12.3 APPOINTMENT OF DEPARTMENT OFFICERS

12.3.1 Contract Departments. The chairs and vice chairs of departments that are staffed by exclusive contract shall be appointed in accordance with the exclusive contract and shall be subject to removal in accordance with the terms of that contract. The remainder of this Section 12.3 applies to the chairs of all non-contract departments.

12.3.2 Nomination. The chair of each department shall be an appointee to the Active Staff who possesses the qualification as specified in these Bylaws. The Nominating Committee, as named in the Bylaws, shall propose a slate for chairs of each department of the Medical Staff. The prospective chair of each department shall be in agreement to serve in that position. All nominees' names shall be forwarded to the Medical Executive Committee for final decision. The selected nominees will then be proposed for approval by the Board.

The term for a department chair shall be for two (2) years commencing with appointment. He/she shall serve until the end of the term and/or until his/her successor is chosen.

12.3.3. Vacancies. A vacancy in the office of department chair shall be filled by the vice chair. A vacancy in the office of department vice chair shall be filled by special election if one year or more remains in the term and otherwise filled by MEC appointment, subject to Board approval.

12.3.4 Removal of a Department Officer. Any elected department officer may be removed from office for (1) failure to perform the duties of the position in a timely and appropriate manner, or (2) physical or mental disability that renders the officer incapable of performing the essential functions of the position. Removal of a department officer may be initiated by a petition signed by at least 66 percent of the voting members in the department and submitted to the President. The vote of 60 percent of the voting members in the department (at a meeting or by mail or email ballot) is required to remove an officer, but no such removal shall be effective unless and until it has been ratified by the MEC and by the Board. The Board, after consultation with the MEC, may remove a department chair if the Board determines either of the above grounds for removal exists.

12.4 DEPARTMENT FUNCTIONS

12.4.1 Meetings. Each department shall meet as often as necessary, as determined by the department chair. 

12.4.2 Department Rules and Regulations. Each department shall adopt appropriate rules and regulations for the department which shall govern the conduct of department functions and affect only that department. Department rules and regulations shall not duplicate or contradict the Medical Staff Bylaws or the Rules and Regulations of the Medical Staff. Department rules and regulations become effective only after approved by the MEC and the Board.

XIII. MEDICAL STAFF OFFICERS

13.1 OFFICERS

13.1.1 Offices. The officers of the Medical Staff shall be the President of the Medical Staff, the President-Elect and the Secretary/Treasurer. The at-large Members of the MEC provided for in Section 14.2.1.6 are not Medical Staff officers but shall be chosen using the same procedures by which Medical Staff officers are selected.

13.1.2 Term of Office. Medical Staff officers shall serve for a two (2)-year term, except a President-Elect who fills a vacancy in the office of President of the Medical Staff who may serve for the balance of his predecessor's term and his/her own two (2) -year term. Each officer serves until his successor is selected and assumes the office.

13.1.3 Officer Qualifications. Medical Staff officers shall be Active Staff Members of the Medical Staff for at least three (3) years and must maintain Active Staff membership. If a Medical Staff officer ceases to be an Active Staff Member, the office becomes vacant. All nominees for Medical Staff office must also have participated in Medical Staff affairs, as evidenced by active participation on committees or holding departmental office or other Medical Staff leadership position, and shall have demonstrated good leadership and communication skills and be willing to participate in leadership continuing education programs.

13.1.4 Conflicting Positions. An individual may not simultaneously serve in more than one elected Medical Staff or department office at the Hospital. An individual who serves as an elected Medical Staff or department officer, or member-at-large of the medical executive committee, of another hospital may not serve as a Medical Staff or department officer or at-large MEC Member at the Hospital; unless there is an affiliation between MercyOne Siouxland Medical Center and the other Hospital.

13.2 ELECTION OF MEDICAL STAFF OFFICERS

13.2.1 Nominations. The Nominating Committee shall convene and submit to the Secretary/Treasurer one or more qualified nominees for each office. The names of such nominees shall be reported to the Medical Staff at least 30 Days prior to the annual meeting.

Nominations may also be made by petition signed by at least 10 percent of the members of the Active Staff and filed with the Secretary-Treasurer at least two (2) working Days prior to the annual meeting. As soon thereafter as reasonably possible, the names of these additional nominees shall be accepted from the floor.

If, before the election, any of the individuals nominated for an office shall refuse, be disqualified from, or otherwise be unable to accept nomination, then the Nominating Committee shall submit one or more substitute nominees at the annual meeting, and nominations shall be accepted from the floor.

The above mentioned nomination process will not apply to the office of the President. The President-Elect, upon the completion of his/her term of office in that position, will immediately succeed to the office of the President.

13.2.2 Election. No later than October 31st in an election year, the Medical Staff Office shall mail or email a ballot to each voting Member. The list of Members eligible to vote shall be determined as of the first day of the month immediately preceding the month during which ballots are distributed. The ballot shall be accompanied by notice of the deadline by which completed ballots must be received in order to be counted. Voting by proxy shall be permitted. Write-in candidates are not permitted. The ballots will be tabulated by persons designated by the President of the Medical Staff.

13.2.3 Voting Procedures. The candidate who receives a majority of the votes cast for an office shall be elected, subject to Board approval. If no candidate receives a majority of the votes cast for an office, a second ballot shall be distributed to choose between the two candidates who received the highest number of votes. The second ballot shall be mailed or emailed in the same manner as the first ballot. The winning candidates, following Board approval, shall take office on January 1st following the election. The MEC may establish additional election rules or procedures that are consistent with these Bylaws.

13.2.4 Vacancies. A vacancy in the office of President of the Medical Staff shall be filled by the President-Elect. A vacancy in the office of President-Elect shall be filled by special election if one year or more remains in the term, otherwise it will be filled by MEC appointment, subject to Board approval. The special election will be conducted as soon after the vacancy occurs as possible following the general mechanisms outlined in the nomination process of these Bylaws. A vacancy in the office of Secretary/Treasurer shall be filled by MEC appointment.

13.2.5 Removal. Any elected Medical Staff officer may be removed from office for (1) failure to perform the duties of the position in a timely and appropriate manner, or (2) physical or mental disability that renders the officer incapable of performing the essential functions of the position. Removal of a Medical Staff officer may be initiated by a petition signed by at least 66 percent of the voting Members and submitted to the MEC. The vote of 60 percent of the voting Members (at a meeting or by mail or email ballot) is required to remove an officer, but no such removal shall be effective unless and until it has been ratified by the Board. The Board, after consultation with the MEC, may remove a

Medical Staff officer if the Board determines either of the above grounds for removal exists.

13.3 DUTIES OF THE PRESIDENT OF THE MEDICAL STAFF

The President shall serve as the chief administrative officer of the Medical Staff and as such shall perform the following:

13.3.1 Aid in coordinating the activities and concerns of the Hospital administration and of the nursing and other Patient care services with those of the Medical Staff.

13.3.2 Attend the meetings of the Board and be accountable to the Board, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the Patient care monitoring and evaluation process and other quality improvement functions delegated to the Medical Staff.

13.3.3 Develop and implement, in cooperation with the department chairs, methods for credentials review and for delineation of privileges, continuing education programs, utilization review, concurrent monitoring of practice, and retrospective Patient care review.

13.3.4 Prior to taking the office on January 1st, the newly elected President will appoint the department chairs (subject to Board approval) and the Medical Staff representatives to Medical Staff and Hospital management committees with participation and consultation by Hospital administration.

13.3.5 Communicate and represent opinions, policies, concerns, needs and grievances of the Medical Staff to the Board, the Chief Executive Officer and other officials of the Medical Staff.

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

13.3.7 Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff and vote in the event of a tie.

13.3.8 Serve as chair of the Medical Executive Committee and as Ex Officio member of all other Medical Staff committees.

13.4 DUTIES OF THE PRESIDENT-ELECT OF THE MEDICAL STAFF

The President-Elect of the Medical Staff shall perform the following:

13.4.1 Duties delegated by the President.

13.4.2 Attend meetings of the MEC and vote as an Active Medical Staff Member.

13.4.3 Preside and function with the full authority and responsibility in the President's absence.

13.4.4 Perform the duties of the President when the President is temporarily unavailable, if immediate action is needed.

13.4.5 Assume the office of President if the President is removed or resigns and upon expiration of the President's term of office.

13.4.6 Call meetings on the order of the President.

13.4.7 Such additional duties as may be assigned to him/her by the President, the Medical Executive Committee, or the Board.

13.5 DUTIES OF THE SECRETARY/TREASURER OF THE MEDICAL STAFF

The Secretary/Treasurer of the Medical Staff shall perform the following:

13.5.1 Keep minutes of all general Medical Staff meetings.

13.5.2 Attend to all Medical Staff correspondence and perform such other duties as ordinarily pertain to the office.

13.5.3 Oversee the Medical Staff's funds and report to the Medical Staff periodically regarding the status of the Medical Staff's finances.

13.5.4 Perform the duties of the President when both the President and President-Elect are temporarily unavailable, if immediate action is needed.

13.5.5 Be a member of the Medical Executive Committee and vote as an Active Medical Staff Member.

13.5.6 Be a member of the Bylaws Committee and preside over the Bylaws Committee when needed.

13.6 ADDITIONAL OFFICERS

13.6.1 The Board may, after considering the advice and recommendations of the Medical Staff, appoint additional Practitioners to medico-administrative positions within the Hospital to perform such duties as prescribed by the Medical Executive Committee and the Board, or as defined by amendment to these Bylaws. To the extent that any such officer performs any clinical function, he/she must become and remain a Member of the Medical

Staff. In all events, he/she must be subject to these Bylaws, the Rules, and to the other policies of the Hospital.

Any Physician whose engagement by the Hospital requires membership on the Medical Staff shall not have his/her Medical Staff privileges terminated without access to the same Due Process as is provided for any other Member of the Medical Staff.

XIV. COMMITTEES

14.1 DESIGNATION AND STRUCTURE

Committees and Officers:

The chairs of all Medical Staff committees, and the officers of the Medical Staff shall be elected or appointed in accordance with the provisions of the Bylaws and shall be subject to the approval of the Board prior to assuming their duties in those offices. Said individuals shall act on behalf of the Hospital when performing their duties under the Bylaws and shall perform such additional duties as may be assigned from time to time by the Board or by the Chief Executive Officer.

General Provisions

14.1.1.1 Committees of the Medical Staff shall be designated as standing or special. Standing committees shall be those committees created to fulfill functions delineated in these Bylaws. Special committees shall be those committees that the Medical Executive Committee shall from time to time determine to be necessary.

14.1.2 Term

14.1.2.1 All standing committee appointments shall be for a period of two (2) years.

14.1.3 Committee Chair

14.1.3.1 The chair of each committee shall be appointed by the President of the Medical Staff with final approval by the Board.

14.1.4 Authority

14.1.4.1 All committees of the Medical Staff, except the Medical Executive Committee, are subject to the authority of and shall report to the MEC.

Unless otherwise provided in these Bylaws or directed in writing by the MEC, any committee may recommend any action to the MEC by the vote of a majority of its members present at a meeting in which a quorum is present.

14.1.5 Conflict Resolution

14.1.5.1 Each Active Staff Member may challenge any Rule, Regulation, Policy or procedure established by the MEC through the following process:

14.1.5.1.1 The Member submits to the President of the Medical Staff his/her challenge to the Rule or Policy in writing, including any recommended changes to the Rule or Policy.

14.1.5.1.2 At the MEC meeting that follows such notification, the MEC shall discuss the challenge and determine if it will change the Rule or Policy.

14.1.5.1.3 If changes are adopted, they will be communicated to the Medical Staff. At such time, each Active Staff Member may submit written notification of any further challenge(s) to the Rule or Policy to the President of the Medical Staff.

14.1.5.1.4 In response to a written challenge to a Rule or Policy, the MEC may, but is not required to, appoint a task force to review the challenge and recommend potential changes to address concerns raised by the challenge.

14.1.5.1.5 If a task force is appointed, the MEC will take final action on the Rule or Policy based on the recommendations of the task force.

14.1.5.1.6 Once the MEC has taken final action in response to the challenge, with or without recommendations from a task force, any Medical Staff Member may submit a petition signed by 25% of the Active Medical Staff Members requesting review and possible change of a Rule, Regulation, Policy or procedure. After receiving a petition, the MEC will follow the adoption procedure outlined in Article XVIII.

14.1.5.2 If the Medical Staff votes to recommend directly to the Board an amendment to the Bylaws, Rules or Regulations, or Policies that is different from what the MEC has recommended, the following conflict resolution process shall be followed:

14.1.5.2.1 The MEC shall have the option of appointing a task force to review the differing recommendations of the MEC and the Medical Staff, and recommend language to the Bylaws, Rules and Regulations, or Policies that is agreeable to both the Medical Staff and the MEC.

14.1.5.2.2 Regardless of whether the MEC adopts modified language, the Medical Staff shall have the opportunity recommend alternative language directly to the Board. If the Board receives differing recommendations for Bylaws, Rules and Regulations or Policies from the MEC and the Medical Staff, the Board shall have the option of appointing a task force to study the basis of the differing recommendations and to recommend appropriate Board action.

14.1.5.2.3 Regardless of whether the Board appoints such a task force, the Board shall have final authority to resolve the differences between the Medical Staff and the MEC. At any point in the process of addressing a disagreement between the

Medical Staff and MEC regarding the Bylaws, Rules and Regulations, or Policies, the Medical Staff, MEC or Board shall each have the right to recommend using an outside facilitator to assist in addressing the disagreement. The final decision regarding whether to use an outside resource and the process that will be followed in so doing is the responsibility of the Board.

14.2 MEDICAL EXECUTIVE COMMITTEE

14.2.1 Composition. The Medical Executive Committee shall consist of:

- 14.2.1.1 President of the Medical Staff who shall serve as Ex Officio, chairperson and shall preside at meetings.
- 14.2.1.2 President-Elect of the Medical Staff.
- 14.2.1.3 Secretary/Treasurer of the Medical Staff,
- 14.2.1.4 Chair of each clinical department (the department vice chair shall attend and vote in the absence of the chair),
- 14.2.1.5 Chairs of the Critical Care, Quality Review, and Credentials Committees.
- 14.2.1.6 Four (4) other Active Staff Members who are elected as members-at-large of the MEC. (Section 13.2.4 and 13.2.5 provisions regarding removal and vacancies also apply). **One** of these positions will be reserved for an Advanced Practice Professional.
- 14.2.1.7 The following Ex Officio Committee members: the CEO and Chief Medical Officer shall serve without vote. These officers may sit with committee approval when it is in executive session.

An individual who serves on the MEC in more than one voting capacity is nevertheless limited to one vote.

14.2.2 Duties. The Medical Executive Committee shall:

- 14.2.2.1 Coordinate the activities and general policies of the various departments.
- 14.2.2.2 Receive, coordinate and act upon (including making recommendations to the Board, when appropriate) the reports and recommendations of the departments, Medical Staff committees, and any other activity group that reports to the MEC, and coordinate policies proposed by these sources.
- 14.2.2.3 Implement policies of the Hospital that will affect the Medical Staff.

- 14.2.2.4 Provide liaison among the Medical Staff, the Chief Executive Officer, and the Board.
- 14.2.2.5 Keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the Hospital.
- 14.2.2.6 Enforce Hospital and Medical Staff Rules in the best interest of Patient care and of the Hospital with regard to all persons who hold appointment to the Medical Staff.
- 14.2.2.7 Refer all questions of clinical competence, Patient care and treatment, case management or inappropriate behavior of any Medical Staff Member to the Board for appropriate action.
- 14.2.2.8 Be responsible to the Board for the implementation of the Hospital's quality assessment plan as it affects the Medical Staff.
- 14.2.2.9 Review the Bylaws, Policies, Rules and Regulations, and associated documents of the Medical Staff regularly and recommend such changes as may be necessary or desirable.
- 14.2.2.10 Acts on behalf of the Medical Staff between meetings of the organized medical staff.

14.2.3 Meetings. The MEC shall meet in at least 10 of twelve months per year.

14.2.4 Modification of Duties. The duties delegated to the MEC pursuant to these Bylaws may be modified by amending these Bylaws in accordance with Article XIII.

14.3 BYLAWS COMMITTEE

14.3.1 Composition. The Bylaws Committee shall consist of Active Members of the Medical Staff.

14.3.2 Duties. The Bylaws Committee shall review the Bylaws regularly and at the request of the MEC or the Board. All proposed amendments to the Bylaws shall be referred to the Bylaws Committee for review and recommendation. The Committee shall submit its recommendations to the MEC.

14.3.3 Meetings. The Bylaws Committee shall meet as needed.

14.4 CREDENTIALS COMMITTEE

14.4.1 Composition. The Credentials Committee shall consist of Active Staff Members in a variety of specialties.

14.4.2 Duties. The Credentials Committee shall:

14.4.2.1 Review and evaluate the credentials of all applicants for initial Medical Staff membership and/or Clinical Privileges or renewal thereof and make recommendations to the MEC regarding appointment, reappointment, delineated Clinical Privileges, Staff category and department.

14.4.2.2 Act on requests for Clinical Privilege modifications in accordance with Section 5.2.

14.4.2.3 Develop, in conjunction with department chairs criteria for granting Clinical Privileges, to submit to the MEC and Board for approval and use in the credentialing and privileging process.

14.4.2.4 Develop credentialing policies, to submit to the MEC and Board for approval and use.

14.4.2.5 Review comments or questions that arise and review information available regarding the clinical competence and behavior of Members currently appointed to the Medical Staff and of those practicing as Advanced Practice Professionals and, as a result of such review, to make a report of its findings and recommendations.

14.4.2.6 Regularly review and recommend amendments to the credentials manual.

14.4.3 Meetings. The Credentials Committee shall meet in accordance with these Bylaws to accomplish its duties, shall maintain a permanent record of its proceedings and action and shall report its recommendations to the MEC, Chief Executive Officer and the Board. The chair of the Credentials Committee shall be available to meet with the Board or its applicable committee on all recommendations that the Credentials Committee may have.

14.5 CRITICAL CARE COMMITTEE

14.5.1 Composition. The Critical Care Committee shall consist of Active Medical Staff Members and Hospital personnel who have special knowledge, skills, or interest in the critical care units of the Hospital.

14.5.2 Duties. The Critical Care Committee shall:

14.5.2.1 Oversee the function of the critical care intensive care units and advise on any key issues that impact the intensive care services.

14.5.2.2 Assure quality Patient care through review of data and identification of opportunities for improvement for critical care Patients.

14.5.2.3 Develop processes to improve specific outcomes related to critical care Patient population.

14.5.2.4 Conduct peer review for omissions of critical indicators.

14.5.2.5 Develop and implement procedures to ensure Patient safety.

14.5.3 Meetings. The Critical Care Committee shall meet at least quarterly.

14.6 INFECTION CONTROL COMMITTEE

14.6.1 Composition. The Infection Control Committee shall consist of Active Medical Staff Members and Hospital personnel who have special knowledge, skills or interest in communicable diseases and health care-acquired infections.

14.6.2 Duties. The Infection Control Committee shall oversee the Hospital's infection control program, which provides for prevention, control and investigation of infections and communicable diseases within the Hospital; education regarding the principles and practices for preventing transmission of infectious agents within the Hospital; confirmation that the Hospital's quality assurance program addresses identified infection control problems; and implementation of effective infection control corrective action plans as needed.

14.6.3 Meetings. The Infection Control Committee shall meet at least quarterly.

14.7 NOMINATING COMMITTEE

14.7.1 Composition. The Nominating Committee shall consist of the President-Elect (who shall preside), Medical Staff President, Secretary-Treasurer, the Chairpersons from the Departments of Family Medicine, Internal Medicine, and Surgery, along with the Chief Medical Officer, and the CEO – who both shall act as Ex Officio.

The Nominating Committee and its chair shall be appointed by the new President of the Medical Staff with the approval of the MEC, 30 Days prior to the annual meeting, as described in Section 13.2.

14.7.2 Duties. The Nominating Committee shall perform the duties described in Section 13.2.1.

14.8.3 Meetings. The Nominating Committee shall meet as necessary to perform its duties under the Bylaws.

14.8 PHARMACY AND THERAPEUTICS COMMITTEE:

14.8.1 Composition. The Pharmacy and Therapeutics Committee shall consist of Active Medical Staff Members and one member each from Pharmacy, Nursing Services and Hospital administration.

14.8.2 Duties. The Pharmacy and Therapeutics Committee shall:

14.8.2.1 Develop and approve all drug utilization policies and procedures relating to the selection, distribution, handling, use, and administration of drugs and diagnostic testing materials within the Hospital to improve Patient care and minimize the potential for hazard including drug errors. This will include all significant drug reactions.

14.8.2.2 Review, recommend and monitor utilization and safety of all nutritional supplements.

14.8.2.3 Approve the Hospital's formulary system and changes thereto.

14.8.3 Meetings. The Pharmacy and Therapeutics Committee shall meet at least quarterly.

14.9 QUALITY AND MEDICAL STAFF PEER REVIEW COMMITTEES

14.9.1 Quality and Medical Staff Peer Review Committee

14.9.1.1 Composition. The Quality and Medical Staff Peer Review Committee shall consist of Medical Staff Members in a variety of specialties.

14.9.1.2 Duties. The Quality and Medical Staff Peer Review Committee shall:

14.9.1.2.1 Oversee the activities of the process of the Focused Professional Practice Evaluations as well as the Ongoing Professional Practice Evaluations. It shall review and make recommendations to the MEC regarding cases referred to it, all as described in Medical Staff Policy relating to professional practice evaluations.

14.9.1.2.2 Be responsible for reviewing and making recommendations relative to clinical outcomes, including complication of care and mortality reviews and review results of all external reviews performed and all Joint Commission required reviews (such as transfusion appropriateness, tissue review, invasive radiology review, ECT, autopsy, etc.).

14.9.1.2.3 Review issues related to Medical Staff professional behavior (at the request of the respective department chair).

14.9.1.2.4 Review and make recommendations relative to Patient and physician satisfaction.

14.9.1.2.5 Review medical errors, sentinel events, and root cause analyses related to Patient safety.

14.9.1.2.6 Review utilization management and medical record content and completion.

14.9.1.2.7 Address matters referred by the chair or another Member of the Medical Staff which may give rise to significant quality of care or Patient safety concerns.

14.9.1.3 Meetings. The Quality & Medical Staff Peer Review Committee shall meet as necessary to perform its duties under the Bylaws.

14.10 CONTINUING MEDICAL EDUCATION

14.10.1.1 Composition. The Continuing Medical Education Committee consists of current members of the Medical Executive Committee.

14.10.1.2 Duties. The Continuing Medical Education Committee shall:

14.10.1.2.1 Develop and plan programs of continuing education that are designed to keep the Medical Staff informed of significant new developments, and new skills in medicine that are responsive to the Medical Staff quality assurance program.

14.10.1.2.2 Evaluate through the quality monitoring program, the effectiveness of the educational programs developed and implemented.

14.10.1.2.3 Act upon continuing education recommendations from the MEC, the departments, or other performance improvement functions of the Medical Staff.

14.10.1.2.4 Maintain a permanent record of educational activities and submit periodic reports to the MEC concerning these activities, specifically

including the relationship to the findings of the performance improvement functions of the Medical Staff.

14.10.1.3 Meetings. The Continuing Medical Education Committee shall meet as necessary to perform its duties under the Bylaws.

14.11 INSTITUTIONAL REVIEW BOARD (IRB)

14.11.1.1 The IRB Committee will be responsible for the review, enforcement, and formal approval of the use of investigational and/or experimental drugs in the Hospital. A Medical Staff Policy describing the purpose and process on the review of such drugs has been developed and approved by the Medical Executive Committee. Any revisions to this Policy must be reviewed and approved by the Medical Executive Committee as well as the Board.

14.12 SPECIAL COMMITTEES

The President of the Medical Staff may form and appoint the members of special committees which he/she determines to be necessary or advisable. The purpose and duties of special committees shall be defined and shall not overlap with the authority and duties of any other committee. Special committees shall confine their activities to their assigned duties and shall be dissolved by the President upon completion of the activity for which they were appointed.

14.13 OTHER COMMITTEES

The MEC may create anew, eliminate, or combine committees when it deems such actions are in the best interest of the Hospital and the Medical Staff. The composition, duties, and meeting guidelines for other committees shall be outlined in the Medical Staff Policy and Procedure Manual. (See the Policy and Procedure Manual for the complete list of other standing and Medical Staff committees.)

Composition/Appointment

A Medical Staff committee established to perform one or more of the functions required by these Bylaws shall be composed of Members of the Active and Courtesy staff and may include, where appropriate, Advanced Practice Professionals and representation from Hospital administration, Nursing Service, Medical Records, Pharmaceutical Services, Social services, and any such other Hospital departments as appropriate to the function(s) to be discharged. Unless otherwise specifically provided, the committee chair shall be appointed by the President of the Medical Staff with final approval by the Board. The Physician members of the respective committees shall be appointed by the chair of that particular committee. The administrative staff member shall be appointed by the Chief Executive Officer. The President of the Medical Staff and the Chief Executive Officer, or their respective designees, shall serve as Ex Officio.

XV. PROFESSIONAL PRACTICE REVIEW FUNCTIONS

15.1 PROFESSIONAL PRACTICE/PEER REVIEW FUNCTIONS OF MEDICAL STAFF AND ADMINISTRATION

15.1.1 The Medical Staff is organized in a manner to provide ongoing review of the professional practices of the Hospital, for the purposes of striving to reduce morbidity and mortality and to improve the care of Patients. Such review includes the quality and necessity of care provided and the preventability of complications and deaths. To the extent any committee of the Medical Staff performs such functions, that committee is hereby designated as a committee assigned professional practice review functions. The committees so designated include, but are not limited to, the investigative, hearing and appeal bodies described in Articles VI, VIII, X and XI and the following committees, which are further described in these Bylaws: Medical Executive, Credentials, Cancer Care, Infection Control, Quality and Medical Staff Peer Review, and Pharmacy and Therapeutics.

15.1.2 Professional practice review functions are also performed in the various clinical departments of the Medical Staff, the clinical programs of the Hospital, by the Medical Staff officers, by Hospital administration, and by the participants in the proceedings that are described in Articles VI through XI, all of whom are assigned professional practice review functions.

15.1.3 Employees of the Hospital are assigned and perform professional practice review functions by providing information, records, data and knowledge to, gathering information for, and otherwise assisting, individuals and committees in the performance of their professional practice review functions.

15.1.4 All minutes and reports created, recommendations and communications made, and actions taken with respect to credentialing, professional practice or peer review, quality assessment or related matters by the Board or its committees or Medical Staff departments or committees and/or individuals assigned a review function on behalf of the Hospital are deemed to be covered, as applicable and to the fullest extent by the provisions of the federal Health Care Quality Improvement Act, Iowa Code Sections, 135.40 and 135.42, and 147.135, and/or the provisions of any federal or state statute providing protections from disclosure and immunity for peer review records or related activities.

15.2 BOARD'S AUTHORITY AND FUNCTIONS

All professional practice review functions are carried out under the direction and authority of the Board of Trustees, which itself carries out professional practice review functions,

such as receiving and acting on the reports and recommendations of committees and individuals assigned such functions.

15.3 CONFIDENTIALITY OF INFORMATION

All minutes, reports, records, data, and knowledge collected by or for individuals and committees assigned professional practice review functions shall be confidential, shall be used only for carrying out such functions, and shall be made available only to other persons and entities that have been assigned such functions for the Hospital or as otherwise required by law.

XVI. MEETINGS

16.1 REGULAR MEDICAL STAFF MEETINGS

16.1.1 Meeting Schedule. Regular meetings of the Medical Staff shall be held annually.

16.1.2 Notice. Notice of the time, date and place of regular Medical Staff meetings shall be published via regular Medical Staff communication channels at least five (5) Days prior to the meeting.

16.1.3 Rules of Order. The rules determined by the President of the Medical Staff shall govern the proceedings of all Medical Staff meetings, except where inconsistent with these Bylaws.

16.1.4 Quorum and Voting. Those voting Members present constitute a quorum for the conduct of business at regular Medical Staff meetings. Except as otherwise provided in these Bylaws, the vote of a majority of the voting Members present at a meeting at which there is a quorum constitutes action by the Medical Staff.

16.2 SPECIAL MEDICAL STAFF MEETINGS

16.2.1 Special Meetings. Special meetings of the Medical Staff shall be called by the President at the request of the MEC, the Board, or upon written request of 10 percent of the voting Members. At a special meeting, no business shall be transacted except that stated in the notice calling the meeting.

16.2.2 Notice. Notice of the time, date and place of a special Medical Staff meeting shall be published via regular Medical Staff communication channels at least five (5) business Days prior to the meeting. For exceptional reasons, a meeting may be called on 24-hour notice to all Members.

16.2.3 Quorum and Voting. The same quorum and voting standards for regular Medical Staff meetings apply to special Medical Staff meetings.

16.3 DEPARTMENTAL MEETINGS

Each department shall meet as often as the department chair deems necessary. The chair of the department shall report the results of department meetings to the MEC. Minutes of these meetings shall be kept. Notice of the time, date and place of each department meeting shall be sent by regular communication channels.

16.4 MEDICAL STAFF COMMITTEE MEETINGS

16.4.1 Meeting Schedule. Committees shall meet as specified in the Bylaws and otherwise at the discretion of the committee chair, the President, the Board, or on request of three (3) or more members of the committee.

16.4.2 Notice. Notice of the time, date and place of a committee meeting shall be published via regular Medical Staff communication channels at least five (5) Days before the meeting. For exceptional reasons, a meeting may be called on 24-hour notice to all members.

16.4.3 Attendance. Attendance at committee meetings shall be recorded.

16.4.4 Quorum and Voting. The presence of thirty-three (33) percent of the voting members of the active medical staff at The Medical Executive Committee (MEC), the Credentials Committee and the Medical Staff Quality/Peer Review Committee will constitute a quorum for the transaction of business. Quorum for Department/clinical service meetings or medical staff committees other than those listed will be those voting members present. Except as otherwise provided in these Bylaws, the vote of a majority of voting committee members present at a meeting at which there is a quorum constitutes action by the committee. A committee member shall not vote on a matter that directly involves himself.

16.4.5 Minutes. Minutes of all committee meetings shall be kept and filed in the Medical Staff office. Minutes shall be provided to the MEC as necessary for review and upon request.

XVII. MEDICAL STAFF POLICIES AND RULES AND REGULATIONS

The MEC may adopt, change and repeal Medical Staff Policies and Rules and Regulations consistent with these Bylaws, as it may from time to time deem advisable for the proper conduct of the work of the Medical Staff, effective upon Board approval. Neither the MEC nor the Board may unilaterally amend Medical Staff Policies or the Rules and Regulations. These Bylaws shall not restrict the Medical Staff's ability to adopt, change, or repeal Medical Staff Policies and Rules and Regulations consistent with these Bylaws, effective upon Board approval. The procedures for giving notice of proposed Medical Staff Policies and Rules and Regulations and amendments thereto shall be addressed in a Medical Staff Policy.

XVIII. BYLAW AMENDMENTS

18.1 PROPOSALS TO AMEND

Proposals to amend these Bylaws in any respect may be initiated by (a) MEC (b) a petition signed by at least 10% of the voting Members or (c) by the Board. Neither the Medical Staff nor the Board may unilaterally amend these Bylaws. When either MEC or the Medical Staff propose changes and before it votes, the proposed amendment will be communicated to the other party.

18.2 REVIEW OF PROPOSAL

The proposal shall be submitted in writing to the Secretary/Treasurer. Immediately upon receipt of the proposed amendment, the Secretary/Treasurer shall send the proposed amendment to the Bylaws Committee for timely review and recommendation. The MEC shall consider the proposed amendment and the recommendation of the Bylaws Committee and shall prepare a written report of its recommendation regarding the proposal.

18.3 VOTING

At least 10 Days before the scheduled vote, the proposed amendment and the MEC's recommendation regarding the proposal shall be published to the Medical Staff via regular Medical Staff communication channels. The proposed amendment shall be submitted to vote by secret ballot at a Medical Staff meeting or by mail or email ballot. The affirmative vote of 66% of the voting Members who cast a vote shall be required to approve the proposed amendment. If the proposed amendment is adopted by the Medical Staff, the proposed amendment, together with the report of the Bylaws Committee and MEC, shall be submitted to the Board for consideration.

18.4 ADOPTION

A proposed amendment to these Bylaws that is approved by the voting Members pursuant to Section 18.3 may be finally adopted or rejected by the Board at its next or any subsequent meeting. Bylaw changes adopted by the Medical Staff shall become effective following approval by the Board.

18.5 ADOPTION AND AMENDMENT OF APPENDICES

The Medical Staff may adopt additional rules, regulations, and policies as necessary to carry out its functions and meet its responsibilities under these Bylaws. A rules and regulations and policies manual may be used to organize these additional documents. The Medical Staff may delegate this responsibility to the MEC.

Proposed amendments to the Rules and Regulations or Policy manual may be originated by the MEC. The MEC will communicate the proposed amendment to the Medical Staff prior to a vote. The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC,

any of these documents may be adopted, amended, or repealed, in whole or in part, and such changes shall be effective when approved by the Board.

In addition to the process described above, the Medical Staff may recommend amendments to any Rules, Regulations, or Policies directly to the Board by submitting a petition signed by 10% of the Members of the Active Staff. On presentation of such petition, the adoption process outlined in Section 18.4 will be followed.

Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

If the Medical Staff does not delegate the responsibility of adopting and amending Medical Staff Rules and Regulations, the Joint Commission allows the MEC to enact rules and regulations that are necessary for legal or regulatory compliance after receiving approval by the Board (MS.01.01.01 EP11.)

The MEC and the Board may adopt such provisional amendments to the Rules and Regulations that they deem necessary for legal or regulatory compliance. After adoption, the MEC will communicate these provisional amendments to the Rules and Regulations to the Medical Staff for review. If the Medical Staff approves of the provisional amendment, the amendment will stand. If the Medical Staff does not approve of the provisional amendment, the conflict resolution mechanism noted in Section 14.1.5 shall be utilized. If a substitute amendment is then proposed, it will follow the usual approval process.

Approved by the Medical Staff this _____ day of _____, 2011.

President
MercyOne Siouxland Medical Center
Medical Staff

Approved by the MercyOne Siouxland Medical Center Board this _____ day of _____, 2011.

Secretary
MercyOne Siouxland Medical Center Board