BYLAWS OF THE
MEDICAL STAFF

WASHINGTON REGIONAL MEDICAL CENTER
FAYETTEVILLE, ARKANSAS

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PREAMBLE

These Bylaws are adopted for the purpose of providing for the organization of the Medical Staff of Washington Regional Medical Center ("Washington Regional") and to provide a framework for self-governance in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes. The Board of Directors of Washington Regional has requested that the Physicians and Dentists practicing on its Medical Staff participate with the Board in the oversight of the quality of medical care and the standards of practice at Washington Regional. The best interests of patients of Washington Regional will be protected by carrying out this responsibility in an organized manner as an integral part of the overall Hospital governance structure, subject to the ultimate authority of the Board of Directors.

Only Members duly appointed by the Board of Directors shall be permitted to independently provide care to patients in Washington Regional. These Bylaws are to be construed in conformity with applicable hospital licensing laws, applicable accreditation guidelines, and federal and Arkansas regulatory requirements. These Bylaws do not constitute an express or implied contract between or among any individual, committee, or entity, unless otherwise expressly determined by Arkansas law. The Physicians and Dentists granted a Medical Staff appointment and clinical privileges at Washington Regional through these Bylaws are not considered employees of Washington Regional, except as set forth in any specific employment agreement between a Physician or Dentist and Washington Regional.

DEFINITIONS

As used herein, the following definitions shall be defined as follows:

1. **Administrator** shall mean the President & Chief Executive Officer or Executive Vice President and Administrator of Washington Regional.
2. **Allied Health Professional** shall mean an individual, other than a Physician or Dentist, who is duly licensed and credentialed to provide clinical services to patients within his professional competence and the limits established by the Medical Staff, the Board, and the applicable Arkansas practice acts. Allied Health Professionals may not be members of the Washington Regional Medical Staff but are eligible for Practice Authorization as provided in the *Washington Regional Medical Center Policy Governing Allied Health Professionals.*
3. **Applicant** means any Physician or Dentist applying for appointment or re- appointment to the Medical Staff and/or Clinical Privileges at Washington Regional.
4. **Board** means the Board of Directors of Washington Regional Medical Center, an Arkansas non-profit corporation, the governing body that has the overall responsibility for the management of Washington Regional.
5. **Board Certified** or **Board Certification** means holding a certificate issued by an appropriate national specialty board recognized by the American Board of Medical Specialties, the American Board of Oral and Maxillofacial Surgery, the American Osteopathic Association, the American Board of General Dentistry or an equivalent specialty board approved by the Board after considering the recommendations of the Medical Executive Committee.

6. **Bylaws** shall mean Bylaws of the Medical Staff of Washington Regional.
7. **Chief of Staff** means the chief officer of the Medical Staff elected by the Medical Staff.
8. **Clinical Privileges or Privileges** means the permission granted to a Member to render specific diagnostic, therapeutic, medical, dental or surgical services to patients after consideration of the Applicant's qualifications and the Washington Regional environmental characteristics including facilities, equipment, number and type of qualified support personnel and resources.
9. **Day** shall mean calendar days unless otherwise specified.
10. **Dentist** shall be interpreted to include a doctor of dental surgery or doctor of dental medicine.
11. **Department** shall mean either the Department of Medicine or the Department of Surgery of Washington Regional.
12. **Executive Committee** means the Medical Executive Committee of the Medical Staff that shall constitute the governing body of the Medical Staff.
13. **Ex-Officio** means service as a member of a body by virtue of an office or position held and, unless otherwise expressly stated, shall include the right to vote.
14. **Licensed Independent Practitioners** means those Allied Health Professionals identified as "Licensed Independent Practitioners" in the *Washington Regional Medical Center Policy Governing Allied Health Professionals*.
15. **Medical Staff** means all Physicians and Dentists who have been duly appointed to the Medical Staff of Washington Regional by the Board and who shall be entitled, to the extent provided in the Bylaws, to vote on issues hereunder.
16. **Medical Staff Year,** as used in these Bylaws, shall mean the calendar year.
17. **Member** means those Physicians and Dentists who have been appointed to the Medical Staff and whose privileges have not expired or been revoked.
18. **Physician** shall be interpreted to include both doctors of medicine (M.D.s) and doctors of osteopathy (D.O.s), or degrees with equivalent medical education and training as are approved and recognized by the Arkansas State Medical Board.
19. **Practice Authorization** means the specific scope of practice and permission granted to an Allied Health Professional to participate in the provision of specific patient care services, treatments, and procedures subject to the conditions imposed in the Bylaws, Rules and Regulations, the rules, regulations, and policies of Washington Regional, and applicable state and federal laws and regulations.
20. **Rules and Regulations** shall mean the Medical Staff rules and regulations as are adopted from time-to-time in accordance with these Bylaws.
21. **Services** shall mean those divisions within a Department which exist pursuant to Article VI of these Bylaws.
22. **Washington Regional** means Washington Regional Medical Center, an Arkansas nonprofit corporation.

For editorial consistency, theses Bylaws apply with equal force to both sexes whenever a gender term is used.

ARTICLE I

NAME

1.0 The name of this association shall be the Medical Staff of Washington Regional Medical Center.

ARTICLE II

PURPOSE

2.1 The purpose of this association shall be:

A. to ensure that all patients admitted to Washington Regional or treated as outpatients receive the best possible care consistent with the resources available;

B. to promote a high level of professional performance of all Members authorized to practice at Washington Regional through the appropriate delineation of the Clinical Privileges that each Member may exercise at Washington Regional and through an ongoing evaluation of each Member's performance;

C. to support educational activities in the interest of improving patient care, the skills of persons providing health services, and the promotion of the general health of
the community; and to provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

D. to provide a means whereby issues of common concern to the Medical Staff, Board, and Administrator may be discussed and satisfactorily resolved;

E. to initiate and maintain rules and regulations for the self-government of the Medical Staff; and

F. to meet hospital standards established by the Arkansas Department of Health, the Centers for Medicare and Medicaid Services ("CMS"), and The Joint Commission.

ARTICLE III

AUTHORITY OF THE BOARD OF DIRECTORS

3.1 By accepting membership on the Medical Staff and specific Clinical Privileges at Washington Regional, each Member accepts the Board as the ultimate governing authority of Washington Regional and by such acceptance agrees to abide by the Bylaws and the Rules and Regulations. Each Member agrees to abide by any and all policies adopted by the Medical Staff, and the Board of Washington Regional, including, but not limited to, those relating to disruptive behavior, impairment, and sexual harassment.

3.2 The Board delegates responsibilities for the quality of medical care to the Members, who, by accepting appointment to the Medical Staff and Clinical Privileges, do assume that responsibility. No delegation by the Board is absolute, and the Board may rescind, alter, modify, or suspend its delegation at its discretion.

3.3 The Medical Staff is an integral part of Washington Regional and not considered a separate entity. Theses Bylaws shall serve as a framework for self-governance of Medical Staff activities and are not intended to create an entity separate from Washington Regional. The Physicians and Dentists granted Clinical Privileges at Washington Regional through these Bylaws are not considered employees of Washington Regional, except as set forth in any specific written agreement between a Physician or Dentist and Washington Regional indicating such. The Board of Directors retains the right and obligation to make final decisions regarding Medical Staff matters and to initiate action when required to protect Washington Regional patients and to further the provision of quality care.

ARTICLE IV

MEDICAL STAFF MEMBERSHIP

4.1 Nature of Medical Staff Membership

Medical Staff Membership and Clinical Privileges shall be extended only to qualified, competent, and licensed Physicians/Dentists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to and membership on the Medical Staff shall confer on the Member only such admitting and Clinical Privileges as have been granted by the Board in accordance with these Bylaws. No Physician or Dentist shall admit or provide services to patients at Washington Regional unless he has been granted appropriate Clinical Privileges in accordance with the procedures set forth in these Bylaws.

4.2 No Entitlement to Membership

4.2.1 No individual shall be entitled to membership on the Medical Staff or to the exercise of Clinical Privileges merely by virtue of the fact that such individual:

A. is licensed to practice a profession in this or any other state;

B. is a member of any particular organization;

C. has had in the past, or currently has, medical staff membership or privileges at any hospital.

4.2.2 A Physician employed by Washington Regional or an affiliate of Washington Regional is not automatically granted Medical Staff membership or Clinical Privileges. An employed Physician is subject to the qualifications and application process and all other provisions of these Bylaws. A Physician's termination of employment by Washington Regional or an affiliate of Washington Regional for any reason shall automatically result in the contemporaneous termination of Medical Staff membership and Clinical Privileges, without any due process rights under these Bylaws, if the Physician's written employment agreement specifically so provides.

4.3 Non-Discrimination Policy

4.3.1 Appointment to the Medical Staff and/or the grant of Clinical Privileges shall not be approved or denied on the basis of an individual's gender, age, creed, religion, color, national origin, or disability.

4.4 Qualifications for Membership

4.4.1 To be qualified for Medical Staff membership and/or Clinical Privileges at Washington Regional, each Applicant for Medical Staff appointment, reappointment or Clinical Privileges must provide adequate documentation evidencing that the Applicant:

A. Has graduated from an Accreditation Council for Graduate Medical Education, American Osteopathic Association, or American Dental Association approved and accepted medical, osteopathic, or dental school;

B. Has successfully completed a residency training program in each specialty for which the Applicant seeks Clinical Privileges that is accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the Commission on Dental Accreditation which would entitle the Applicant to sit for a board examination administered by the American Board of Medical Specialties, the American Osteopathic Association, the American Association of Osteopathic Specialists, the American Board of

Oral and Maxillofacial Surgery or the American Board of General Dentistry, in accordance with the Applicant's degree and specialty or subspecialty, as appropriate. Each Department may establish more specific criteria pertaining to that Department.

C. Has a current, unrevoked, unrestricted and unencumbered license to practice his profession in the State of Arkansas.

D. Has documented education, background, experience, training, and demonstrated current clinical competence within his field of practice as demonstrated by: (i) recent experience in the management and care of patient's representative of those admitted to Washington Regional and (ii) an ability to perform the Clinical Privileges requested;

E. Has a current unrestricted U.S. Drug Enforcement Administration Certificate of Registration reflecting an Arkansas practice address, where applicable to his practice.

F. Has a record that is free from current Medicare or Medicaid sanctions and is not on the United States Department of Health and Humans Services, Office of Inspector General ("OIG") List of Excluded Individuals/Entities;

G. Does not have any physical or mental health impairment that cannot be reasonably accommodated and which would interfere with the fulfillment of his responsibilities as a Member of the Medical Staff and the exercise of the specific Clinical Privileges requested by the Applicant;

H. Has current, documented evidence of annual tuberculosis screening and tuberculosis prevention conducted in accordance with the *Rules Pertaining to the Control of Communicable Diseases – Tuberculosis*, as promulgated and amended from time-to-time by the Arkansas Department of Health, together with documented evidence of any other health screening or vaccination that may be required of Physicians practicing within a general hospital under applicable federal or Arkansas law;

I. Has professional liability insurance issued by an insurer acceptable to the Board and authorized to issue such insurance in the State of Arkansas in a minimum amount of not less than $1,000,000.00 per claim/$3,000,000.00 annual aggregate. The Applicant or Member, as the case may be, shall supply all requested information, including the name of the present carrier, current limits of coverage, current types of coverage, restrictions on coverage, and whether coverage has been continuously maintained since the Applicant or Member first obtained professional liability coverage. If any Applicant or Member changes insurance carriers for any reason, or has his or her insurance coverage terminated or limited for any reason, such Applicant or Member shall immediately notify the Medical Staff office in writing. Failure to continuously

maintain such insurance throughout the term of the applicable period of Medical Staff appointment shall result in automatic suspension of the Member's Medical Staff appointment and Clinical Privileges in accordance with Section 9.3.2 of these Bylaws;

J. If requested by Washington Regional, has completed a statement concerning conflict of interest.

4.4.2 Board Certification.

In addition to the qualifications for membership and Clinical Privileges set forth in Section 4.4.1, all Applicants who seek appointment to the Medical Staff after November 1, 1999 must meet the Board Certification requirements set forth in this Section 4.4.2. Physicians whose initial appointment occurred (i) prior to November 1, 1999 and (ii) who have not, subsequent to that date, attained Board Certification in their specialty or subspecialty, shall not be required to satisfy the Board Certification requirements of this Section 4.4.2 as a condition to their appointment or reappointment to the Medical Staff.

A. An Applicant seeking appointment to the Community Staff category shall be required to demonstrate that he has at one time since completion of his residency program attained Board Certification in his specialty or subspecialty.

B. Except as otherwise provided in subsections C, D, or E below, an Applicant seeking appointment to the Active Staff category, the Courtesy Staff category, the Provisional Staff category, or the Consulting Staff category must demonstrate that he satisfies the Board Certification requirements of this Section 4.4.2 as a condition to their appointment or reappointment to the Medical Staff.

C. Except as otherwise provided in this section, if the Physician practices in a primary care field, such that only one type of board certification is available within the Physician's practice area, the Physician must have current board certification for the Physician's practice area. However, if the Physician is not Board Certified in his specialty at the time the application is submitted, the Physician must be eligible to take the next board examination and such Board Certification must be obtained in the specialty in which the Physician practices on or before five (5) years from the date on which the Physician completed his residency program.

D. Except as otherwise provided in this section, if the Physician practices in a subspecialty within a specialty, the Physician must have current Board Certification within such subspecialty for the Physician's practice area. However, if the Physician is not Board Certified in his subspecialty at the time the application is submitted, the Physician must be eligible to take the next board examination and such Board Certification must be obtained in the subspecialty in which the Physician practices on or before five (5) years from the date on which the Physician completed his residency or fellowship program, as applicable to his practice area.

E. Except as otherwise provided in this section, if the Physician practices in more than one practice area, the Physician must have current Board Certification in each field within which he practices. However, if the Physician is not Board Certified in his additional specialty at the time the application is submitted, the Physician must be eligible to take the next board examination and such Board Certification must be obtained in each specialty in which the Physician practices on or before five (5) years from the date on which the Physician completed the applicable residence or fellowship program applicable to each practice area.

F. If a Physician fails to demonstrate compliance with the Board Certification requirements set forth in this Section 4.4.2 at the time of initial appointment or reappointment, the Physician's application will be considered incomplete and the Physician will be deemed not to meet the minimum eligibility requirements for appointment or reappointment, as the case may be, to the Medical Staff and none of the due process rights set forth in Article IX of these Bylaws shall apply. Under exceptional circumstances, the Medical Executive Committee may grant an extension beyond the five (5) year requirement.

4.4.3 In addition to the qualifications for membership and Clinical Privileges set forth in Section 4.4.1 and Section 4.4.2, all statutory and regulatory requirements of the federal government and the State of Arkansas regarding the credentialing of physicians are incorporated herein and become qualifications for membership.

4.5 Submission of Application

4.5.1 All requests for applications for appointment or reappointment to the Medical Staff and/or requests for Clinical Privileges shall be forwarded to the Medical Staff Office. Upon receipt of the request, the Medical Staff Office will provide the Applicant with an application package, which will include a complete set of the Medical Staff Bylaws, Rules and Regulations or reference to a URL address for this information. This application package will set forth the eligibility requirements for Medical Staff appointment and/or Clinical Privileges and the performance expectations for individuals granted Medical Staff appointment and/or Clinical Privileges.

The application shall contain a request for specific Clinical Privileges desired by the Applicant and shall require detailed information necessary to verify the Applicant's professional qualifications and suitability for appointment or reappointment to the Medical Staff and/or grant of Clinical Privileges and include, at a minimum:

A. A completed, signed and dated application form.

B. Copies of all requested documents and information necessary to confirm that the Applicant meets each of the qualifications for membership and Clinical Privileges as are set forth in Section 4.4 of these Bylaws.

C. Information from all prior and current professional liability insurance carriers

concerning the Applicant's professional liability insurance litigation (e.g., malpractice) experience, including a detailed description of all claims, suits, settlements and judgments, if any, during the previous ten (10) years.

D. Current Board Certification status, including current eligibility and a description of Board Certification examinations taken, passed, or failed.

E. A description of the Applicant's healthcare-related employment and medical staff appointment history, including terminations, challenges, or decisions pending, voluntary resignations/relinquishments, and pending investigations.

F. Relevant morbidity and mortality data and relevant practitioner-specific data, as compared to aggregate data, when available, compiled as a result of professional practice review conducted by an organization that currently privileges the Applicant, together with a description of the most recent twelve (12) months of clinical activities, including approximate number, type, and location of patients treated.

G. The names, physical and electronic addresses, and telephone numbers of not less than three (3) physicians, medical faculty or other qualified professional references, as appropriate, who within the past twelve months have had extensive experience in observing and working with the Applicant, and who can provide adequate information pertaining to the Applicant's present professionalism, communication skills, interpersonal skills, and technical and clinical knowledge, skill and judgment. At least one reference shall be from an individual practicing within the same specialty area as that held by the Applicant. Note: Only one peer reference is required at the time of reappointment, which shall be provided by the Applicant's Service Chairman.

H. The names, physical and electronic addresses, telephone and facsimile numbers of the applicable department chairpersons or clinical service chairpersons for the clinical areas within which the Applicant practiced, worked or trained at any and all hospitals or other institutions at which the Applicant has practiced, worked or trained. Such references should be obtained from individuals designated by the institution and not only individuals designated by the Applicant.

I. With respect to a new Applicant, a record that is free from felony convictions within the last five (5) years, or misdemeanor convictions, arrests or indictments that raise questions of undesirable conduct which could injure the reputation of the Medical Staff or Washington Regional. After initial appointment, Section 9.3.5 of these Bylaws applies to Members with felony or misdemeanor convictions or indictments.

J. Submit relevant information pertaining to the Applicant's physical and mental health. All Applicants are deemed to have consented, as a condition to submitting an application for appointment or reappointment, to immediate

testing of blood and/or urine for controlled substances and/or alcohol, in circumstances where reasonable suspicion is found to exist, upon request of both the Chief of Staff and the Administrator.

Reasonable suspicion may include, but not be limited to, erratic behavior, apparent inability to perform work duties, odor of alcohol or controlled substances, or any other behavior that reasonably gives rise to concern for patient, Medical or Allied Health Staff, or employee safety, and that reasonably appears to result from consumption or use of alcohol or controlled substances.

K. Authorization permitting the Medical Staff to conduct or secure a criminal background check.

L. Authorization permitting the Medical Staff to consult with members of the medical staffs of other hospitals with which the Applicant has been associated and with other individuals who may have information bearing on the Applicant's qualifications.

M. Authorization permitting third parties to release all records and documents that, in the judgment of the Chief of Staff, the Department Chair, the Service Chief, the Credentials Committee, the Medical Executive Committee, or the Board of Directors, may be material to a proper evaluation of the Applicant's qualifications.

O. Information pertaining to any action, including any past or pending investigation, which has been undertaken regarding the Applicant's professional status or qualifications, including but not limited to, licensure, staff membership and/or clinical privileges, insurance panels, and professional organizations.

P. Information pertaining to the Applicant's voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges. A voluntary termination is considered a disciplinary action when the relinquishment is done to avoid an adverse action, preclude an investigation, or is done while the individual is under investigation related to professional conduct.

Q. An acknowledgment that the Applicant has received a copy (or has been given access to) and read the Medical Staff Bylaws, Rules and Regulations, and that he agrees to be bound by the terms of the same, as they may be amended from time-to-time, if he is granted Medical Staff appointment and/or Clinical Privileges, and to be bound by the terms thereof without regard to whether or not he is granted Medical Staff appointment and/or Clinical Privileges in all matters relating to consideration of their application.

R. A release from liability for all representatives of Washington Regional and the Medical Staff for their acts performed in good faith in evaluating the Applicant's application and qualifications.

S. A release from liability for all individuals and organizations who in good faith provide information to Washington Regional and its Medical Staff concerning the Applicant, including otherwise privileged or confidential information.

T. An application fee in such amount as may be established by the Medical Staff Office from time-to-time as necessary to cover the actual costs incurred in processing an application.

U. A copy of a current picture identification card issued by a state or federal agency (e.g., driver's license or passport) or current hospital identification card from a hospital at which the Applicant is currently privileged.

V. An agreement to participate with Washington Regional as an organized health care arrangement under HIPAA as to Washington Regional patients, and to comply with Washington Regional policies on protected health information and Washington Regional's Notice of Privacy Practices as to Washington Regional patients.

W. A requirement to provide accurate answers to the following questions, including a requirement to immediately notify the MEC in writing, directed to the Chief of Staff, should any of the information regarding these items change during the period of the Applicant's Medical Staff membership. If the Applicant answers any of the following questions affirmatively and/or provides information identifying a problem with any of the following items, the Applicant will be required to submit a detailed written explanation of the circumstances involved.

1. Have any disciplinary actions been initiated or are any pending against you by any licensure board?
2. Has your license to practice or registration in any state ever been relinquished, denied, challenged, limited, suspended, or revoked, whether voluntarily or involuntarily?
3. Have you ever been requested to surrender your professional license?
4. Have you ever been suspended, sanctioned, excluded or otherwise restricted from participating in any private, federal or state health insurance program (for example, Blue Cross, Medicare or Medicaid)?
5. Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program?
6. Has your DEA certificate of registration ever been relinquished, limited, denied, suspended or revoked?
7. Have you ever been named as a defendant in any criminal proceedings or been arrested or charged with a crime?
8. Has your employment, medical staff membership, or clinical privileges

ever been reduced, suspended, diminished, revoked, refused, or limited at any hospital or other health care facility, whether voluntarily or involuntarily?

9. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the medical staff before a hospital's or health facility's governing board made a decision?
10. Have you ever been the subject of a formal or informal disciplinary or corrective action investigation?
11. Have you ever been disciplined, formally reprimanded, or been the subject of an investigation because of alleged inappropriate conduct, disruptive behavior, or unprofessional actions (e.g., sexual harassment)?
12. Have you ever been the subject of focused individual monitoring at any hospital or health care facility other than to confirm competency immediately following an initial grant of clinical privileges?
13. Have any professional liability claims or lawsuits ever been brought against you or are any currently pending?
14. Have any judgments been rendered against you or have any settlements been made on your behalf in connection with professional liability cases?
15. Have you ever been denied or refused coverage, had coverage canceled, or had specific clinical privileges excluded from coverage by a professional liability insurance carrier?
16. Have you ever entered into an agreement with federal or state government as a result of violations of federal or state law?
17. If you are not currently board certified please answer the following:

    a. Have you ever been examined by any specialty board, but failed to pass the examination?
    b. Have you applied for the certification exam?
    c. Have you ever been accepted to take the certification exam?
    d. If so, what dates are you scheduled to sit for the exam?

4.5.2 Applicant's Burden. Each Applicant seeking appointment to the Washington Regional Medical Staff and the grant of Clinical Privileges shall have the burden of:

A. Producing information deemed adequate by the Medical Executive Committee and Board for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.
B. Establishing qualification for and competence to exercise the Clinical Privileges requested.
C. Providing evidence that all statements made and information given in connection with the application are true and correct.

Until the Applicant has provided all information required in Section 4.5.1, or if the need arises for new, additional, or clarifying information in the course of reviewing the application, as reasonably requested by the Department Chair, Credentials Committee Chair, Chief of Staff, or

Medical Staff Office, the application for appointment will be deemed incomplete, the application will not be processed, and the Applicant will not be entitled to the procedural rights set forth in Article IX of these Bylaws. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the Applicant. If the requested information is not received within thirty (30) days of the Applicant's receipt of that letter, the application will be deemed voluntarily withdrawn and the Applicant will be so notified. The Chair of the Credentials Committee shall have the discretion to extend such time for good cause. Should information provided in the initial application form change during the period within which the application is being considered, the Applicant has the burden to immediately provide the Credentials Committee and Medical Staff Office information about such change.

4.5.3 Preliminary Review. Upon receipt of the application, the Chief Medical Officer, Department Chair or Credentials Committee Chair, in collaboration with the Medical Staff Office, will determine if the requirements set forth in the above sections have been met and whether the application can be deemed complete. In the event the requirements of the above sections are not met, the Applicant will be notified that the application is not complete and that the Applicant is ineligible to apply for Medical Staff membership and/or Clinical Privileges. An incomplete application will not be processed and the Applicant will not be entitled to the procedural rights set forth in Article IX of these Bylaws. If the requirements of the above sections are met, the application will be deemed complete and accepted for further processing.

4.5.4 Primary Source Verification. Upon receipt of an application deemed complete after the preliminary review addressed in Section 4.5.3, the Medical Staff Office will verify current licensure, training, and current competence from the primary source, whenever feasible, or from a credentials verification organization (CVO) such as the Arkansas State Medical Board's Centralized Credentials Verification Service (CCVS). When all of the information in the application has been verified, the application shall be sent to the Service Chairman for the Department in which the Applicant seeks Clinical Privileges.

4.6 Application Evaluation

4.6.1 An expedited review and approval process may be utilized for initial appointment. All applications for Medical Staff appointment and/or Clinical Privileges shall be classified into one of the following two categories.

A. **Type I**: A completed application that does not raise concerns as identified in Type II. Applicants whose application has been classified as Type I will be granted Medical Staff appointment and/or Clinical Privileges after review and action by each of the following: the Service Chair, the Department Chair, the Credentials Committee Chair, the Medical Executive Committee, and Board.

B. **Type II**: If one or more of the following criteria are identified in the course of reviewing a completed and verified application, the application will be classified as Type II. Applications classified as Type II must be reviewed and acted on by the Service Chair, the Department Chair, Credentials Committee, Medical Executive Committee, and the Board. At all stages of this review process, the

burden is on the Applicant to provide evidence that he meets the criteria for appointment to the Medical Staff and the grant of the requested Clinical Privileges. Criteria that shall result in an application being assigned a Type II classification include, but are not necessarily limited to, the following:

1. The Applicant has one or more references that raise questions or concerns;

2. One or more discrepancies are discerned from information received from the Applicant and references or verified information;

3. The Applicant has been the subject of complaints with respect to quality of care or professional conduct, including disruptive behavior;

4. The Applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization;

5. The Applicant is, or has been, under investigation by a state medical board or has been the subject of prior disciplinary actions or legal sanctions;

6. The Applicant has had a significant number or an unusual pattern of malpractice cases filed against him within the past five (5) years;

7. There exists a discrepancy between the Applicant's requested Clinical Privileges and the clinical privileges the Applicant has previously been granted;

8. The Applicant's request for Clinical Privileges is not reasonable in light of the Applicant's experience, training, or demonstrated current competence, and/or is not in compliance with applicable criteria;

9. Adverse information concerning the Applicant is revealed from the conduct of the applicable criminal background check;

10. The Applicant has been the subject of complaints and/or been counseled, formally or informally, for disruptive behavioral, sexual harassment, or impairment issues;

11. The Applicant has an adverse National Practitioner Data Bank report;

12. The Applicant has potentially relevant physical and/or mental health problems;

13. The Applicant has been removed from a managed care panel for reasons of professional conduct or quality;

14. The final recommendation of the Medical Executive Committee is adverse

or with limitation;

15. Such other reasons identified in good faith by a medical staff leader, the Administrator, or Chief Medical Officer which raise questions about the qualifications, competency, professionalism or appropriateness of the Applicant for Medical Staff membership or Clinical Privileges.

4.6.2 Applicant Interview. All Applicants for appointment to the Medical Staff and/or the grant of Clinical Privileges may be required to participate in an interview at the discretion of the Service Chair, Credentials Committee, Medical Executive Committee or Board. The interview may be conducted in person or by telephone at the discretion of the Washington Regional representatives. The interview may be utilized to solicit information required to complete the credentials file or clarify information previously provided or secured through the application process, e.g., clinical knowledge and judgment, professional behavior, malpractice history, associations or disassociations with other healthcare organizations, or other matters bearing on the Applicant's ability to render quality patient care. The Applicant will be notified if an interview is requested. The Applicant's failure to attend an interview, in the absence of good cause shown, shall be deemed a voluntary withdrawal of the application and the Applicant will not be entitled to the procedural rights set forth in Article IX of these Bylaws.

4.6.3 Service Chair Review.

A. Each application for initial appointment, reappointment, or Clinical Privileges, and all supporting documentation, shall be reviewed by the Service Chair for the Departmental Service to which the Applicant will be assigned if granted Medical Staff appointment and/or Clinical Privileges. The Service Chair reviews the application to evaluate the Applicant's education, training, and experience to ensure that the Applicant meets the established standards for Medical Staff membership and Clinical Privileges. The evaluation shall include inquiries directed to the Applicant's past or current Department Chairs, Service or Section Chiefs, residency program directors, and others who have knowledge as to the Applicant's current licensure status, training, experience, competence, ability to perform the Clinical Privileges requested, and ability to work collegially with others. The Service Chair, in consultation with the Medical Staff Office, shall determine whether the application is forwarded as a Type I or Type II Application.

B. In the conduct of his review, the Service Chair may obtain input from Members within the Department or, where necessary and approved in advance by the Chief Medical Officer, an appropriate external subject matter expert. The Service Chair may request additional information from the Applicant as provided in Section 4.5.2 of these Bylaws or conduct an interview with the Applicant as described in Section 4.6.2 of these Bylaws.

C. Within sixty (60) days after his initial receipt of the completed application, the Service Chair shall forward a specific written report to the Credentials Committee setting forth:

1. A recommendation as to whether the application should be acted on as Type I or Type II;
2. A recommendation to approve the Applicant's request for Medical Staff appointment and/or Clinical Privileges, to approve appointment but modify the requested Clinical Privileges, or to deny appointment and/or Clinical Privileges;
3. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after the initial grant of Clinical Privileges.

D. Where the Service Chair recommendation is to deny appointment, modify the requested Clinical Privileges, or deny all or specific Clinical Privileges, the reason for each such recommendation shall be stated in the Service Chair's written report to the Credentials Committee with appropriate references to any supporting documentation that informed such recommendation.

4.6.4 Credentials Committee Review.

A. **Type I Application.** Where an application is classified Type I, it is presented to the Credentials Committee Chair for review and recommendation. The Credentials Committee Chair shall review the application to evaluate the Applicant's licensure, education, training, and experience to ensure that the Applicant meets the established standards for Medical Staff membership and Clinical Privileges. The Credentials Committee Chair has the discretion to determine whether the application is forwarded as a Type I application or may change the classification to a Type II application. Where the Credentials Committee Chair approves the classification of an application as Type I, the Credentials Committee Chair acts on behalf of the Credentials Committee in recommending approval of the application and forwards the application on to the Medical Executive Committee for further review and recommendation. Nothing herein shall preclude the Credentials Committee from collectively conducting a review of a Type I application in accordance with the procedures applicable to a Type II application, as set forth below.

B. **Type II Application**.

1. Where an application is classified Type II, the Credentials Committee shall collectively conduct a review of the application, the Service Chair recommendation, any supporting documentation, and any other available information that may be relevant to the Applicant's qualifications and suitability for appointment to the Medical Staff and grant of Clinical Privileges. The Credentials Committee shall examine evidence of the Applicant's qualifications, professional competence, character, prior behavior, and ethical standing and shall determine, through information contained in references given by the Applicant and from other sources available to the Credentials Committee, including the written report and findings of the Service Chair, whether the Applicant has established and

satisfied all of the necessary qualifications for appointment to the Medical Staff and the grant of the Clinical Privileges requested. Without limiting the breadth of the permissible areas of inquiry set forth in these Bylaws, the Credentials Committee must evaluate each particular risk area identified in Section 4.6.1.B that resulted in the Applicant's application being assigned a Type II classification.

2. In the conduct of its review, the Credentials Committee may:

   i. obtain input from Members within the Department, the Service, or, where necessary and approved in advance by the Chief Medical Officer, an appropriate external subject matter expert;
   ii. request additional information from the Applicant as provided in Section 4.5.2 of these Bylaws;
   iii. return the application to the appropriate Department or Medical Staff Office with specific instructions to obtain any further information deemed necessary to the Credentials Committee's consideration of the application;
   iv. conduct an interview with the Applicant as described in Section 4.6.2 of these Bylaws;
   v. require the Applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee at the Applicant's expense.

C. Within sixty (60) days after its receipt of the completed application and recommendation of the Service Chair, the Credentials Committee shall forward a specific written report to the Department Control Committee setting forth:

1. A recommendation as to whether the the application should be acted on as Type I or Type II;
2. A recommendation to approve the Applicant's request for Medical Staff appointment and/or Clinical Privileges, to approve appointment but modify the requested Clinical Privileges, or to deny appointment and/or Clinical Privileges;
3. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after the initial grant of Clinical Privileges.

D. Where the Credentials Committee recommendation is to deny appointment, modify the requested Clinical Privileges, or deny all or specific Clinical Privileges, the reason for each such recommendation shall be stated in the Credentials Committee's written report to the Department Control Committee with appropriate references to any supporting documentation that informed such recommendation.

E. Within sixty (60) days after its receipt of the completed application and

recommendation of the Credentials Committee, the Department Control Committee shall forward a specific written report to the Medical Executive Committee, setting forth:

1. A recommendation as to whether the application should be acted on as Type I or Type II;
2. A recommendation to approve the Applicant's request for Medical Staff appointment and/or Clinical Privileges; to approve appointment but modify the requested Clinical Privileges; or deny appointment and/or Clinical Privileges;
3. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after the initial grant of Clinical Privileges.

F. Where the Department Control Committee recommendation is to deny appointment, modify the requested Clinical Privileges, or deny all or specific Clinical Privileges, the reason for each such recommendation shall be stated in the applicable Department Control Committee's written report to the Medical Executive Committee, with appropriate references to any supporting documentation that informed such recommendation.

4.6.5 Medical Executive Committee Review and Recommendation.

A. Expedited Credentialing. Notwithstanding any provision in these Bylaws to the contrary, an application forwarded to the Medical Executive Committee with a Type I classification may be reviewed pursuant to the following process for expedited credentialing. Specifically, not less than three (3) voting Members of the Medical Executive Committee shall constitute a quorum for the sole and limited purpose of expediting the review of Type I applications and recommendations. At least one of the three voting Members shall be the Chief of Staff. A Member who has previously been involved in the consideration of the Type I application at the Service, Department or Credentials Committee levels may not be counted toward the required quorum or otherwise participate in the expedited credentialing process at the Medical Executive Committee level. The Chief of Staff may determine whether the application should be considered through this expedited credentialing process as a Type I application, or converted to a Type II application and referred back to the Department Chair for further action consistent with the requirements set forth in these Bylaws as are applicable to Type II applications. The review and any subsequent approval of a Type I application pursuant to the process outlined in this Section 4.6.5.A shall constitute the act of the Medical Executive Committee as a whole and result in the application being forwarded to the Board for final action. Should any recommendation other than unanimous approval of an application classified as Type I be made pursuant to this expedited credentialing process then, in such event, the application shall be converted to a Type II application and referred back to the Department Chair for further action consistent with the requirements

set forth in these Bylaws as are applicable to Type II applications. Nothing herein shall preclude the Medical Executive Committee from collectively conducting a review of a Type I application in accordance with the procedures applicable to a Type II application, as set forth below.

B. Medical Executive Committee Action.

1. At its next regular meeting after receiving the report and recommendation of the Credentials Committee, the Medical Executive Committee shall consider the report and recommendations of the Service Chair, Departmental Control Committee, Credentials Committee, and any other information available. If the Medical Executive Committee believes that any further information is needed to review the application, the Medical Executive Committee may return the application to the Credentials Committee, or the appropriate Service or Department Chair, with instructions to obtain the requested information, or may obtain the information directly as permitted in Section 4.5.2 and Section 4.6.2 of these Bylaws.

2. The Medical Executive Committee shall forward a specific written report to the Board setting forth:

    a. A recommendation as to whether the application should be acted on as Type I or Type 2;
    b. A recommendation to approve the Applicant's request for Medical Staff appointment and/or Clinical Privileges; to approve appointment but modify the requested Clinical Privileges; or deny appointment and/or Clinical Privileges;
    c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after the initial grant of Clinical Privileges.

3. Where the Medical Executive Committee recommendation is to deny appointment, modify the requested Clinical Privileges, or deny all or specific Clinical Privileges, the reason for each such recommendation shall be stated in the Medical Executive Committee's written report to the Board with appropriate references to any supporting documentation that informed such recommendation.

4. Where the Medical Executive Committee recommendation would entitle the Applicant to request a hearing pursuant to Article IX of these Bylaws, the recommendation shall be forwarded to the Chief Medical Officer. The Chief Medical Officer shall promptly notify the Applicant of such recommendation in accordance with the procedures set forth in Section 9.4.1 of these Bylaws. The application shall not be forwarded to the Board until the Applicant has exercised or has been deemed to have waived the right to a hearing provided in Article IX of these Bylaws.

4.6.6 Board Action.

A. **Type I**. If the application is classified by the Medical Executive Committee as a Type I application, it shall be presented to the Board or an appropriate subcommittee of at least two (2) members of the Board where the application will be reviewed to ensure that the requisite review process and procedures have been followed and that the application meets the established standards for Medical Staff appointment and Clinical Privileges. If the Board or subcommittee agrees with the recommendation of the Medical Executive Committee, the application is approved and the requested appointment and Clinical Privileges are granted for a period not to exceed twenty-four (24) months. If a subcommittee takes the action, it shall be reported to the entire Board at its next scheduled meetings. If the Board or subcommittee disagrees with the recommendation, then the procedure for processing Type II applications will be followed.

B. **Type II**. If the application is classified as a Type II application, the Board shall review the application and vote for one of the following actions:

1. The Board may adopt or reject in whole or in part a recommendation of the Medical Executive Committee or refer the recommendation to the Medical Executive Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for Medical Staff appointment and Clinical Privileges it will grant appointment and Clinical Privileges for a period not to exceed twenty-four (24) months.

2. If the Board's action is adverse to the Applicant, the Administrator shall promptly notify the Applicant of such action in accordance with the procedures set forth in Section 9.4.1 of these Bylaws and the Applicant shall then be entitled to the procedural rights provided in Article IX of these Bylaws.

3. The Board shall take final action in the matter as provided in Article IX of these Bylaws.

C. Notice of Final Decision. Notice of the Board's final decision shall be given through the Administrator to the Medical Executive Committee, the Department Chair and Service Chair of each Department and Service concerned. The applicant shall receive written notice of appointment and any adverse final actions in a timely manner. A notice to appoint or reappoint shall include:

1. the Medical Staff category to which the Applicant is appointed;
2. the Department to which he is assigned;
3. a delineation of the Clinical Privileges granted; and
4. any special conditions attached to the appointment.

4.6.7 Time Frames for Processing Application. All Services, Departments, committees, and representatives of Washington Regional shall make good faith efforts to process applications for appointment and reappointment expeditiously. All general time parameters referenced in these Bylaws shall be measured from the time at which the Applicant furnishes all information that was reasonably requested in accordance with these Bylaws through the submission of a complete application. Such time parameters may be suspended, however, by the Medical Executive Committee for reasonable cause. The time parameters specified shall be for the guidance of the Medical Staff representatives, committee, Service or Department concerned and shall not be deemed to create any right in favor of an Applicant to require the processing of his application within such parameters. Nevertheless, processing of applications should ideally be completed within 270 days of receipt of a completed application, if not sooner, unless any delays are necessitated by the hearing process set forth in Article IX.

4.7 Professional Practice Evaluation

4.7.1 Professional Practice Evaluation of Members

A. **Focused Professional Practice Evaluation of Provisional Members**. All Members appointed to the Provisional category of the Medical Staff and granted Clinical Privileges upon consideration of an initial application for membership shall be subject to a period of focused professional practice evaluation (FPPE) in accordance with the procedures outlined in the *Washington Regional Medical Center Medical Staff Policy on Focused Professional Practice Evaluation*.

B. **Focused Professional Practice Evaluation for Members Granted New Clinical Privileges**. All Members of the Medical Staff who are granted new or additional Clinical Privileges beyond those granted the Member at the time of initial appointment shall be subject to a period of FPPE in accordance with the procedures outlined in the *Washington Regional Medical Center Medical Staff Policy on Focused Professional Practice Evaluation*.

C. **Ongoing Professional Practice Evaluation of Members**. The Medical Staff will also engage in ongoing professional practice evaluation (OPPE) to identify professional practice trends that affect quality of care and patient safety in accordance with the procedures outlined in the *Washington Regional Medical Center Medical Staff Policy on Focused Professional Practice Evaluation.* Information from this evaluation process will be considered in the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of a Member's current clinical competency. In addition, each Member may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process in accordance with the procedures outlined in the *Washington Regional Medical Center Medical Staff Policy on Focused Professional Practice Evaluation*.

4.7.2 Professional Practice Evaluation of Licensed Independent Practitioners

A. **Focused Professional Practice Evaluation of Newly Appointed Licensed Independent Practitioners**. All Licensed Independent Practitioners appointed to the Allied Health Staff and granted Practice Authorization upon consideration of an initial application for membership shall be subject to a period of FPPE in accordance with the procedures outlined in the *Washington Regional Medical Center Medical Staff Policy on Focused Professional Practice Evaluation* as the same may be logically applied to Licensed Independent Practitioners and appropriately tailored to the particular Licensed Independent Practitioner's profession.

B. **Focused Professional Practice Evaluation for Licensed Independent Practitioners Granted New Practice Authorization**. All Licensed Independent Practitioners who are granted new or additional Practice Authorization beyond those granted the Licensed Independent Practitioner at the time of initial appointment to the Allied Health Staff shall be subject to a period of FPPE in accordance with the procedures outlined in the *Washington Regional Medical Center Medical Staff Policy on Focused Professional Practice Evaluation* as the same may be logically applied to Licensed Independent Practitioners and appropriately tailored to the particular Licensed Independent Practitioner's profession.

C. **Ongoing Professional Practice Evaluation of Licensed Independent Practitioners**. The Medical Staff will also conduct ongoing professional practice evaluation (OPPE) of Licensed Independent Practitioners to identify professional practice trends that affect quality of care and patient safety in accordance with the procedures outlined in the *Washington Regional Medical Center Medical Staff Policy on Focused Professional Practice Evaluation* as the same may be logically applied to Licensed Independent Practitioners and appropriately tailored to the particular Licensed Independent Practitioner's profession. Information from this evaluation process will be considered in the decision to maintain existing Practice Authorization, to revise existing Practice Authorization, or to revoke an existing Practice Authorization prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of a Licensed Independent Practitioner's current clinical competency. In addition, each Licensed Independent Practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process in accordance with the procedures outlined in the *Washington Regional Medical Center Medical Staff Policy on Focused Professional Practice Evaluation* as the same may be logically applied to Licensed Independent Practitioners.

4.8 Reappointment

4.8.1 **Criteria for Reappointment**. A Member shall only be approved for reappointment to the Medical Staff and renewal of Clinical Privileges where the Member meets the criteria for initial appointment as identified in Section 4.4 of these Bylaws. The Medical Executive Committee and Board must also determine that the Member provides effective care that is consistent with Washington Regional standards regarding ongoing quality and the hospital performance improvement program. A Member seeking reappointment must provide the information required in Section 4.8.2 of these Bylaws. The grant of new Clinical Privileges to existing Members will follow the process described in Section 4.5, 4.6 and 4.7 of these Bylaws. All reappointments and renewals of Clinical Privileges are for a period not to exceed twenty-four (24) months.

4.8.2 **Information Supplied by the Member**. On or before six (6) months prior to the date of expiration of a Medical Staff appointment or grant of Clinical Privileges, a representative from the Medical Staff Office shall notify the Member of the date of expiration and supply him with an application for reappointment for membership and Clinical Privileges. At least sixty (60) days after the Member's receipt of this notification the Member must return the following to the Medical Staff Office:

A. A completed reapplication form, which shall include any information necessary to update the Member's file with respect to information provided at the time of the Member's initial appointment together with any required new, additional, or clarifying information, and any required fees or dues;

B. Information concerning continuing training and education during the Member's preceding Medical Staff appointment period; and

C. The Member's agreement, as evidenced by signing the reapplication form, to those terms identified in Section 4.5 of these Bylaws.

D. Payment in full of any outstanding balance owed by the Member for annual dues.

4.8.3 **Information Gathered by Medical Staff Office**. The Medical Staff Office shall collect and verify the following information as part of the reappointment process:

A. That information identified in Section 4.5.1.W of these Bylaws;

B. A summary of clinical activity at Washington Regional during the Member's most recent period of appointment;

C. That data maintained in the Member's Medical Staff file maintained in accordance with the ongoing professional practice evaluation of the Member performed in accordance with Section 4.7 of these Bylaws;

D. Performance and conduct at Washington Regional and other healthcare organizations at which the Member has provided any clinical care since the last

appointment or reappointment period, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;

E. Attestation Statement submitted by the Applicant attesting to having obtained continuing medical education hours as required for renewal of the Applicant's Arkansas medical license and commensurate with the Clinical Privileges being requested;

F. Compliance with Medical Staff policy on timely and accurate completion of medical records;

G. Compliance with applicable bylaws, rules and regulations of the Medical Staff and Washington Regional; H. Verification of current licensure;

I. National Practitioner Data Bank query;

J. Authorization permitting the Medical Staff to conduct or secure a criminal background check;

K. Where sufficient peer review data is not available to evaluate competency, one or more peer recommendations, to be furnished in a format as approved by the Credentials Committee, submitted by other physicians who have observed the Applicant's clinical and professional performance and can evaluate the Applicant's current patient care, medical/clinical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, system-based practice and physical, mental and emotional ability to perform requested Clinical Privileges; and

L. Malpractice history for the past two (2) years which is primary source verified by the Medical Staff Office with the Applicant's professional liability insurance carrier(s).

4.8.4 **Untimely or Insufficient Submission**. Failure, without good cause, to provide any required information, at least sixty (60) calendar days prior to the expiration of the Member's current appointment will result in a cessation of processing of the application and automatic expiration of the Member's Medical Staff appointment and Clinical Privileges when the current appointment period is concluded. Once the information is received, the Medical Staff Office will proceed to verify the information and shall notify the Applicant of any additional information that may be needed to resolve any discrepancies or doubts about performance or material contained in the Member's credentials file.

4.8.5 **Processing of Application for Reappointment**.

A. An Application for Reappointment may be designated for expedited review in accordance with the process set forth in Section 4.6 of these Bylaws.

B. An Application for Reappointment will be reviewed and acted upon in accordance with the process set forth in Sections 4.6.3 through 4.6.7 of these Bylaws. For the purpose of reappointment an "adverse recommendation" by the Board as used in Section 4 means a recommendation or action to deny reappointment, or to deny or restrict requested Clinical Privileges or any action which would entitle the Applicant to a fair hearing under Article IX of these Bylaws.

4.9 Reapplication Following Adverse Decision

An Applicant who has received a final adverse decision regarding an application for appointment or reappointment, or whose Clinical Privileges have been terminated during their term, shall not be eligible to reapply to the Medical Staff for a period of two years from the date such adverse action became final. Any such reapplication shall be processed as an initial application; however, any such Applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse decision no longer exists.

4.10 Special Conditions for Licensed Independent Practitioners Eligible for Clinical Privileges without Membership

Requests for Practice Authorization from Licensed Independent Practitioners shall be submitted and processed in a parallel manner to requests for Clinical Privileges from Physicians eligible for appointment to the Medical Staff, as those provisions may be logically applied to Licensed Independent Practitioners, so as to ensure appropriate review of a Licensed Independent Practitioner's qualifications by the Medical Staff. The foregoing notwithstanding, no provision of these Bylaws shall be interpreted or construed as conferring upon Licensed Independent Practitioners eligibility for appointment to the Medical Staff or rights and privileges associated with Medical Staff membership. Only those Licensed Independent Practitioners identified in the *Policy Governing Allied Health Professionals* as being approved by the Medical Staff and Board to provide services at Washington Regional are eligible to apply for Practice Authorization. Allied Health Professionals who are identified as Licensed Independent Practitioners within the *Policy Governing Allied Health Professionals* may, subject to any licensure requirements or other limitations imposed by law, the Policy Governing Allied Health Professionals, or these Bylaws, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients.

4.11 Responsibilities for Individual Members

4.11.1 Each Member of the Medical Staff shall:

A. be accessible, as defined in the Rules and Regulations, for the performance of professional and Medical Staff duties and obligations to Washington Regional;

B. provide continuous care and supervision to all patients within Washington Regional for whom the Member has responsibility, or arrange for coverage by another Member who has equivalent Clinical Privileges in the same medical specialty or subspecialty as the Member arranging for substitute coverage;

C. complete a medical history and physical examination (H&P) for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration. A H&P must be completed prior to any surgery or procedure requiring anesthesia services. The Medical Executive Committee may specify in Medical Staff policies additional credentialed allied health practitioners who may perform required H&Ps to the extent permitted under applicable law;

D. perform (or delegate to another practitioner) daily inpatient hospital rounds on any patient for whom they serve as attending Physician;

E. work harmoniously and cooperatively with the Medical Staff, nurses, administration, and all other Washington Regional personnel so as not to adversely affect patient care or interfere with the orderly operation of Washington Regional;

F. accept committee assignments and such other reasonable duties and responsibilities, including professional review activities, consultations, proctoring, quality improvement activities, and emergency services call as may be assigned;

G. have sufficient activity at Washington Regional to allow the appropriate Medical Staff committee to evaluate, in a continuing manner, the current competence of the Member;

H. seek consultation when medically prudent;

I. adhere to the ethical standards of the profession;

J. abide by the Bylaws, Rules, and Regulations of the Medical Staff and Washington Regional;

K. abide by all laws governing the practice of medicine or dentistry, as the case may be;

M. Submit to any pertinent type of health evaluation as requested by the Medical Executive Committee where it appears necessary to protect the health or well-

being of patients and/or staff, or when requested by the Medical Executive Committee or Credentials Committee as part of an evaluation of the Member's ability to exercise Clinical Privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of the Medical Staff Impaired Member Policy;

N. All Members of the Active Medical Staff, under the age of 60, shall be required to serve on the Emergency Department call panel for their specialty or subspecialty. An Active Member who is 60 years of age or older, and who has taken Emergency Department call for twenty (20) years or more at Washington Regional, or who has reached the age of sixty-five (65), regardless of years of service, may request of his Department that he be relieved of the duty of Emergency Department call. The Department's recommendation will be forwarded to the Medical Executive Committee, whose decision will be final. Call responsibility will not be assigned to a particular practice or group, but will be assigned to the individual Member, whether that Member is a solo practitioner or member of a single or multi-specialty group;

O. Maintain confidentiality of patient individually identifiable health information;

P. Prepare and complete in timely and legible fashion medical records for all patients to whom the Member provides care at Washington Regional.

4.11.2 Each Member possessing Privileges at Washington Regional shall report to the Chief of Staff and/or Chief Medical Officer any of the following events within seven (7) days of the occurrence. Failure to abide by this requirement shall be grounds for termination of Clinical Privileges and/or the Member's Medical Staff appointment.

The following events are reportable under this paragraph:

A. any threatened suspension or threatened revocation of the Applicant's or Member's license to practice his profession in any jurisdiction;

B. voluntary or involuntary termination of medical staff membership or voluntary limitation, reduction, or loss of privileges at another hospital;

C. any denial of an Applicant's or Member's application for membership to any hospital staff;

D. any final judgments or settlements involving the Applicant or Member as a defendant in any professional liability action;

E. any suspension, reduction, revocation, or non-renewal of privileges or rights to participate in any health maintenance organization or in any federal healthcare program (e.g., Medicare, Medicaid, or Tricare);

F. any agreement to refrain from exercising any or all clinical privileges in any hospital;

G. any action taken by any other hospital relating to impairment, behavior, or sexual harassment issues;

H. voluntary or involuntary participation in a rehabilitation program or health committee for treatment of an impairment; and

I. any appearance before or any required reports to the Arkansas State Medical Board.

The Member involved in any such events shall, upon request, appear before the Medical Executive Committee and give an accurate explanation of the circumstances involving the individual in any of the foregoing events. In the event the explanation is not satisfactory, corrective action may be initiated pursuant to Article IX of these Bylaws.

4.12 Leave of Absence

4.12.1 **Leave Request**. A Member may, for good cause as determined by the Executive Committee, be granted a leave of absence for a definite period of time not to exceed one (1) year. Requests for leave must be forwarded with a recommendation from the Medical Executive Committee and affirmed by the Board. Absence for longer than one (1) year shall constitute a voluntary resignation of Medical Staff membership and Clinical Privileges, unless the absence is for military service or an exception is made by the Board upon recommendation of the Medical Executive Committee. A request for a leave of absence shall be made in writing and directed to the Chief of Staff stating the anticipated period of time of the leave and the reasons for the requested leave. The Chief of Staff shall transmit the request to the Medical Executive Committee. During the period of a leave of absence, the Member shall not be entitled to exercise his Clinical Privileges.

4.12.2 **Termination of Leave**. Within a reasonable time prior to the conclusion of the leave of absence, the Member may request reinstatement by sending a written request to the Chief of Staff for reinstatement of his Clinical Privileges, which request shall summarize his relevant activities during the period of the leave of absence. The Member shall also provide such other information pertaining to his current competence and ability to meet the minimum qualifications for membership and exercise of Clinical Privileges as may be reasonably requested. In acting upon the request for reinstatement and after consideration of all relevant information, the Medical Executive Committee may recommend reinstatement, either to the same or a different Medical Staff category, and may limit or modify the Clinical Privileges to be extended to the Member upon reinstatement. If the recommendation is for denial of reinstatement, or reduction in Medical Staff category or Clinical Privileges, the Member shall be entitled to the fair hearing rights as provided in Article IX of these Bylaws. The Board shall take final action on a request for reinstatement upon consideration of the recommendation of the Medical Executive Committee. If the Member's current Medical Staff appointment and/or Clinical Privileges is due to expire during the leave of absence, the Member must apply for

reappointment, or his appointment and/or Clinical Privileges shall lapse at the end of the current appointment period.

4.12.3 **Failure to Request Reinstatement**. Failure, without good cause, to request reinstatement or to provide the summary of activities or other information described in this Section 4.12 that may be requested before termination of the leave of absence shall result in automatic termination of the Member's Medical Staff appointment and Clinical Privileges. A Member whose appointment and Clinical Privileges is automatically terminated shall not be entitled to the fair hearing rights provided in Article IX of these Bylaws. A request for Medical Staff appointment subsequently received from a Member so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

ARTICLE V

CATEGORIES OF THE MEDICAL STAFF

5.1 The Medical Staff

5.1.1 The Medical Staff shall be divided into categories of active, courtesy, provisional, community, consulting, honorary, and emeritus Medical Staff categories. In addition, there shall be a House Staff and Medical Student Staff. Determination of each Physician's or Dentist's Medical Staff category shall occur at the time of appointment or reappointment, although a Member may request a change in Medical Staff category at any time during his/her term of appointment. The Executive Committee may, on its own initiative or pursuant to a written request by a Member, recommend a change in the Medical Staff category of a member consistent with the requirements of these Bylaws. Each such recommendation shall be forwarded to the Board of Directors for approval.

5.2 The Active Medical Staff

5.2.1 The active Medical Staff shall consist of Members who:

A. meet all the qualifications for Medical Staff membership as set forth in these Bylaws;
B. are actively engaged in the practice of their specialty at Washington Regional;
C. are privileged to admit and/or attend to patients in Washington Regional;
D. reside in sufficient proximity to Washington Regional to provide continuous care for their patients;
E. are board certified or board eligible in their specialty; and
F. who assume all the functions and responsibilities of membership on the active Medical Staff, including Emergency Department on-call obligations and consultation assignments.

5.2.2 Members of the active Medical Staff shall be appointed to a specific Department and

Service; shall be eligible to vote, hold office, and serve on Medical Staff committees; shall be expected to attend Medical Staff and Departmental meetings; and shall be required to pay annual Medical Staff dues.

5.2.3 Members of the active Medical Staff may admit patients to Washington Regional and may perform an unlimited number of consultations and procedures within the scope of their Clinical Privileges.

5.3 The Courtesy Medical Staff

5.3.1 The courtesy Medical Staff shall consist of Members who:

A. meet all the qualifications for Medical Staff membership as set forth in these Bylaws;
B. who are board certified or board eligible in their specialty;
C. are privileged to perform consults and/or procedures, but are not involved in greater than twenty (20) patient encounters at Washington Regional in any year of their two year Medical Staff appointment term. Patient encounters is defined as interaction with a patient either by admission, as the attending physician, by consultation, or by serving as the primary operator in the performance of a procedure; and
D. assume certain Medical Staff functions and responsibilities, including the provision of Emergency Department on-call obligations if the Department Chair of the Department to which the Courtesy Member is assigned determines there is a need for such coverage within the Courtesy Member's Service.

5.3.2 To be eligible for appointment to the courtesy Medical Staff, the Physician must hold active membership on the medical staff of another acute care hospital located in Washington or Benton County, Arkansas that is licensed by the State of Arkansas as a General Hospital.

5.3.3 Courtesy Members shall be appointed to a specific Department and Service, but shall not be eligible to vote, hold office or serve on committees. Courtesy Members will be required to pay annual Medical Staff dues.

5.3.4 Courtesy Members may be assigned to the active Medical Staff by action of the Medical Executive Committee and Board upon exceeding twenty (20) patient encounters at Washington Regional in any year of their two year Medical Staff appointment term.

5.4 The Provisional Medical Staff

5.4.1 The provisional Medical Staff is the entry level for Applicants who may be considered for advancement to the active or courtesy Medical Staff. All initial appointments to the Medical Staff, or appointees to the Medical Staff after termination of a prior appointment, shall be provisional for a period of at least twelve (12) months. Upon appointment,

provisional staff members shall be assigned to a specific Department and Service. Members of the provisional Medical Staff may not vote, serve on Medical Staff committees, or hold office. Members of the provisional Medical Staff are encouraged to attend Medical Staff meetings and shall be required to pay annual Medical Staff dues.

5.4.2 The provisional Medical Staff is subdivided into two categories:

A. Introductory Provisional Staff
B. Associate Provisional Staff

5.4.3 Introductory Provisional Staff. Introductory Provisional Staff is the initial category of appointment to the Medical Staff. The period of assignment to this category is for no fewer than six (6) months.

A. During the Introductory Provisional Staff period, the Member is required to:

1. Arrange for a proctor to monitor the prescribed number of surgical or medical cases required under Section 4.7.1 of these Bylaws concerning FPPE;

2. Report any severe adverse events related to patient care;

3. Report any malpractice claims against him; and

4. Continuously meet and observe all the requirements set forth in these Bylaws and the Rules and Regulations applicable to the Member's Service.

B. During the Introductory Provisional Staff period the Member's proctor is required to report the results of proctoring in a timely manner to the Service Chairman.

C. During the Introductory Provisional Staff period the Service Chairman is required to report to the Departmental Control Committee any failure of the Member to meet the requirements set forth under 5.4.3 together with any of the following:

1. Placement under the Medical Staff medical records "No Admit Policy;"

2. Any referral of the Provisional Introductory Staff Member made pursuant to the Medical Staff Conduct Policy, Sexual Harassment Policy, or Physician's Health Policy;

3. Complaints against the Member relating to the quality of care;

4. Behavioral concerns;

5. Any peer review activity based on potential or confirmed quality concerns; and

6. Any other reason of concern regarding the Member, insofar as it relates to his or her fitness to be a Member of the Medical Staff.

D. The Provisional Introductory Staff appointment is a probationary period, and the appointment may be terminated at any time.

E. The Service Chairman shall perform a quality of care review of patient records six (6) months after the Member's appointment to the Provisional Introductory Staff. The results of this review shall be communicated both to the Member and in a formal report to the Departmental Control Committee. The report shall specify:

1. The results of the patient care chart review;
2. The results of the Member's proctoring; and
3. The Member's compliance with all requirements applicable to the Provisional Introductory Staff Member.

5.4.4 Associate Provisional Staff.

A. The Department shall vote to approve or deny advancement of the Member from the Introductory Provisional Staff to the Associate Provisional Staff category. Denial of advancement shall result in termination of the Member's Medical Staff appointment and Clinical Privileges.

B. The Department may meet with the Member for the purpose of obtaining additional information to guide its decision whether to advance the Provisional Introductory Member to the Associate Provisional category, but such meeting shall not constitute a hearing. The decision of the Department shall be forwarded to the Executive Committee for final action.

C. Upon advancement to the Associate Provisional Staff category, the Member shall remain in that category for an additional six (6) month period. During this time, the Member shall be required to report to the Medical Staff office and Service Chairman any:

1. Severe adverse events related to patient care;

2. Patient, staff, and physician complaints against the Member;

3. Malpractice claims against the Member; and

4. Continuously meet and observe the requirements set forth in these Bylaws and the Rules and Regulations applicable to the Member's Service.

5.4.5 During this time, the Service Chair is required to report to the Departmental Control Committee any failure of the Member to meet the above requirements, as well as any of the following:

A. Placement under the Medical Staff medical records "No Admit policy;"

B. Any referral of the Provisional Introductory Staff Member made pursuant to the Medical Staff Conduct Policy, Sexual Harassment Policy, or Physician's Health Policy;

C. Complaints against the Member relating to the quality of care;

D. Behavioral concerns;

E. Any peer review activity based on potential or confirmed quality concerns; or

F. Any other reason of concern regarding the Member insofar as it relates to his or her fitness to be a Member of the Medical Staff.

5.4.6 The Departmental Control Committee may require the Member to appear before the committee to explain any concern and to undergo additional proctoring for cause. Failure of the Associate Provisional Member, at any time, to meet the requirements of the Medical Staff shall be cause for corrective action, including reduction, restriction, or termination of Medical Staff appointment and/or Clinical Privileges.

5.4.7 Six (6) months after elevation to the Associate Provisional Staff, the Service Chair shall conduct a review of the following information specific to the Member for the purpose of formulating a recommendation as to whether the Member should be elevated to the Active Staff category.

A. Select cases (including severe adverse events related to patient care);

B. Medical records compliance;

C. All complaints relating to the quality of care;

D. All behavior concerns;

E. Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) conducted pursuant to Section 4.7 of these Bylaws;

F. Complication rates, mortality rates, and other relevant clinical quality indicators;

G. Any reports to the State Medical Board or National Practitioner Data Bank;

H. Any reportable events under Article IV, Section 4.11.2 of these Bylaws;

I. All proctoring outcomes; and

J. Any other concern regarding the Member.

5.4.8 This review shall result in a formal recommendation from the Service Chairman as to whether:

A. The Member should be approved for advancement to the Active or Courtesy staff;

B. The Member should be denied advancement to the Active or Courtesy staff; or

C. Additional information is necessary to adequately determine whether advancement to the Active or Courtesy staff should be approved or denied.

5.4.9 In the event the recommendation of the Service Chair is for advancement of the Member to the Active or Courtesy staff, the recommendation shall be communicated to the Members of the Service. Any active Member of the Service objecting to such action may request, within seven (7) days after the date of such communication, a called meeting of the Service. The action of the Service, whether to approve or deny the Provisional Member's advancement, shall be forwarded to the Departmental and Executive Committees and thereafter to the Board for action.

5.4.10 In the event the recommendation of the Service Chair is other than to approve advancement of the Provisional Member to the Active or Courtesy staff, a Service meeting shall be called and a decision made with respect to advancement. In the event the Service recommendation is other than to approve advancement of the Provisional Member to the Active or Courtesy staff, such recommendation shall be forwarded to the Department for a decision with respect to advancement. In the event the Departmental recommendation is other than to approve advancement of the Provisional Member to the Active or Courtesy staff, the Departmental recommendation shall be forwarded to the Executive Committee. In the event the Executive Committee recommendation is other than to approve advancement of the Provisional Member to the Active or Courtesy staff, the Provisional Member shall be entitled to the procedural rights set forth in Article IX of these Bylaws before the recommendation is sent to the Board. When final action has been taken by the Board, the Administrator shall communicate the decision of the Board to the Provisional Member.

5.4.11 The Department may extend the Introductory Provisional Staff appointment and/or Associate Provisional Staff appointment period for up to an additional three (3) months for the purpose of obtaining additional information necessary to inform a decision as to whether to approve or deny advancement to the Active or Courtesy Staff. A Member shall not remain in either the Introductory Provisional Staff or Associate Provisional Staff category for a period longer than nine (9) months. If after eighteen (18) months in the Provisional category the Member has not received a favorable recommendation for

advancement to the Active or Courtesy staff, the matter shall be forwarded to the Executive Committee who shall investigate and adopt a final recommendation within ninety (90) days as to whether to approve or deny the Provisional Member advancement. In the event the Executive Committee recommendation is other than to approve advancement of the Provisional Member to the Active or Courtesy staff, the Provisional Member shall be entitled to the procedural rights set forth in Article IX of these Bylaws before the recommendation is sent to the Board. When final action has been taken by the Board, the Administrator shall communicate the decision of the Board to the Provisional Member.

5.5 The Consulting Medical Staff

5.5.1 The Consulting Medical Staff shall consist of those Members who provide consultative services to other Members of the Medical Staff. Membership in the Consulting Staff shall be limited to those Physicians who practice in a specialty whose members do not ordinarily assume primary responsibility for the care of patients in Washington Regional. Members of the Consulting Staff shall not have admitting Privileges. Members of the Consulting Staff shall be Board Certified or board eligible in their specialty. They shall not be eligible to vote, hold office or serve on committees, nor shall they be required to pay annual Medical Staff dues. Consulting Members shall be appointed to a specific Department and Service. Consulting Members shall be required to provide Emergency Department on-call consulting coverage if the Department Chair of the Department to which the Consulting Member is assigned determines there is a need for such coverage within the Consulting Member's Service. New appointees to the Consulting Medical Staff shall be subject to peer review by the Service chair or his designee(s) for the purpose of monitoring and assessing quality of care.

5.5.2 Full-time Physician faculty members of Arkansas Children's Hospital and the University of Arkansas for Medical Sciences may be granted appointment to the Consulting staff and Clinical Privileges upon receipt of a proper request from such a qualifying Physician for such appointment and Clinical Privileges together with a copy of the Applicant's credentialing file from their hospital of primary membership.

5.6 The Honorary and Emeritus Medical Staff

5.6.1 The Honorary Medical Staff shall consist of Members who are of outstanding reputation, not necessarily residing in the community.

5.6.2 The Emeritus Medical Staff shall consist of Members who have retired from active medical practice and contributed exemplary service to the Medical Staff. Emeritus Members shall have ceased the practice of medicine at Washington Regional and at the time of their resignation shall have been Members in good standing of the Medical Staff for a period of at least ten (10) continuous years, during which there were no disciplinary actions which resulted in a loss of Clinical Privileges. Appointment to the Emeritus Medical Staff shall be by application of the Member, or by action of the Executive Committee during the reappointment process. Once appointed to the Emeritus Medical

Staff, the Member agrees to maintain his inactive status and is not required to remain a resident in northwest Arkansas, and agrees to all other relevant conditions of Medical Staff membership and all other appropriate professional and ethical standards.

5.6.3 Honorary and Emeritus Members shall not admit patients, attend patients as consultants, vote, hold office, or serve on standing Medical Staff committees. They shall not be required to pay annual Medical Staff dues.

5.6.4 Appointment to and continued membership on the Honorary and Emeritus Medical Staff shall be solely within the discretion of the Executive Committee and the Board. Neither appointment to nor membership on the Emeritus or Honorary Medical Staff shall create any vested rights to such membership and it may be terminated at any time upon the recommendation of the Executive Committee and approval of the Board.

5.7 The Community Staff

5.7.1 The Community Staff shall consist of those Physicians who maintain a clinical practice in the primary or secondary service area of Washington Regional, who desire to be affiliated with Washington Regional and refer patients to Members of the Active or Courtesy Medical Staff, but who do not admit or treat patients in Washington Regional.

5.7.2 Members of the Community Staff:

A. Must continuously maintain a written contractual agreement with a member of the Active Medical Staff (or group of Active Medical Staff Members) to attend to the Community Staff Member's patients who require admission and inpatient care. A copy of this agreement will be provided at the time of initial appointment and reappointment and maintained on file in the Medical Staff Office. Failure to maintain the required agreement during the period of the Community Staff Member's Medical Staff appointment shall result in the automatic termination of the Community Staff Member's Medical Staff appointment without right to the hearing procedures set forth in Article IX.

B. Shall not have delineated Clinical Privileges and, therefore, may not admit, write orders for inpatient care, perform surgical or invasive procedures, or otherwise treat or consult on patients in Washington Regional.

C. May not transfer to another category of the Medical Staff without submitting an initial application for appointment and proceeding through the initial application process set forth in Article IV of these Bylaws.

D. May not vote, or hold Medical Staff office.

E. May visit their patients in Washington Regional, review their patients' medical records and attend Medical Staff, Service and Department meetings, CME functions and social events.

F. Shall be required to pay any Medical Staff dues or fees assessed.

5.7.3 Appointment to the Community Staff is a courtesy only, which may be terminated by the Board upon recommendation of the Medical Executive Committee, with no right to a hearing or appeal.

5.8 The House Staff

5.8.1 The House Staff of Washington Regional shall consist of Physicians who are enrolled in an Accreditation Council for Graduate Medical Education approved residency program, partially or wholly conducted within Washington Regional or The University of Arkansas for Medical Sciences.

5.8.2 Members of the Washington Regional House Staff shall **NOT** be eligible for membership on the Medical Staff, be granted Clinical Privileges, or be entitled to any rights afforded Medical Staff Members, including hearing and appeal rights under these Bylaws.

5.8.3 Members of the Washington Regional House Staff shall be under the supervision of the director of the residency program and the attending Member, each of whom shall monitor the clinical and ethical performance of the House Staff member. Members for the House Staff shall be permitted to perform only those functions set out in training protocols developed by the director of the residency program, which protocols are provided to the Credentials Committee, Medical Executive Committee and Board for approval in advance of any clinical rotation.

5.8.4 Credentialing of the residency staff shall be based upon written recommendation of the director of the residency program, subject to approval by the Credentials Committee, Executive Committee, and Board. Evaluation of the House Staff member's knowledge, skills and overall performance takes place on a regular basis through the residency training program.

5.8.5 Members of the House Staff may perform the functions of an attending physician only under the supervision of the attending Member. The attending Physician, to whom the resident is assigned, shall be responsible for the care of the patient, as well as for reviewing and countersigning the following: admission orders, H&P, discharge summary, discharge order, and all other dictated reports. Attending Members AND a representative of the residency program's faculty must be available for consultation at all times to ensure that questions arising from hospital and Medical Staff Members about the conduct of House Staff members can be answered promptly. In general, the supervising Member will determine the nature of the required supervision, based on the complexity of the patient care situation, the level of training and experience possessed by the House Staff member, and approved residency training protocols. Types of supervision can include, but are not limited to, in person, electronic or telephonic supervision, review of documentation, and submission and review of performance evaluations.

5.8.6 House Staff members may not hold Medical Staff office. They may be appointed to

Medical Staff committees at the recommendation of the residency program director, but are not eligible to vote. They may attend meetings of the Medical Staff for informational purposes.

5.8.7 House Staff members shall provide evidence of an evaluation, regardless of whether the Applicant is a reactor, non-reactor, or converter, in accordance with the applicable section of the Tuberculosis Manual of the Arkansas Department of Health, together with documented evidence of any other health screening or vaccination that may be required of Physicians practicing within a general hospital under applicable federal or Arkansas law.

5.8.8 House Staff members are eligible to practice in the Washington Regional emergency department beginning in their second year of residency, upon appropriate recommendation and under direct supervision of Members credentialed in Emergency Medicine and who are actively participating within the Emergency Department. Direct supervision shall be defined as the physician presence of the Member within the Emergency Department who is immediately available to furnish assistance and direction to the resident in the conduct of their duties.

5.8.9 Members of the House Staff are required to document their professional liability insurance coverage in the amount required by the Medical Staff Bylaws for Members of the Medical Staff.

5.9 Medical Students

5.9.1 All medical student clinical clerkships at Washington Regional must be requested through and coordinated by the University of Arkansas for Medical Sciences, AHEC Northwest, or such other academic medical center or program as may be approved in advance by the Chief Medical Officer.

5.9.2 Each medical student shall present evidence of an annual tuberculosis screening, regardless of whether the Applicant is a reactor, non-reactor, or converter, in accordance with the *Rules Pertaining to the Control of Communicable Diseases- Tuberculosis* as promulgated and amended from time-to-time by the Arkansas Department of Health, together with documented evidence of any other health screening or vaccination that may be required of Physicians practicing within a general hospital under applicable federal or Arkansas law.

5.9.3 All activities of the medical student are the responsibility of the sponsoring Member.

5.9.4 The clinical and ethical performance of the medical student shall be monitored by the sponsoring Member.

5.9.5 Medical students are permitted to perform a history and physical examination and document the findings, as well as clinical observations in the medical record. All such entries in the patient's medical record, including progress notes, shall be reviewed and

countersigned by a Member within twenty-four (24) hours after the entry is made.

5.9.6 Medical students are permitted to write orders if signed by a Member prior to the order being carried out.

5.9.7 Medical students are permitted to perform procedures only under the personal supervision of a Member who is at all times physically present when the procedure is performed.

5.9.8 Medical students shall be considered part of the Washington Regional "workforce" (as that term is defined at 45 C.F.R. §160.103) for the limited purpose of complying with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §1320d, ("HIPAA") and the HIPAA Privacy and Security Regulations codified at 45 C.F.R. Part 160, Part 162 and Part 164. Each medical student shall sign an appropriate confidentiality statement prior to performing any clinical rotation at Washington Regional.

ARTICLE VI

CLINICAL DEPARTMENTS

6.1 Organization of Clinical Departments and Services

6.1.1 The Medical Staff shall be divided into clinical Departments. These Departments shall be the Department of Medicine and the Department of Surgery. Each Department shall be organized as a separate component of the Medical Staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities as specified herein. A Department may be further divided, as appropriate, into Services, which shall be directly responsible to the chair of the Department within which they function. Department Services shall each have a chair selected and entrusted with the authority, duties, and responsibilities as specified herein. Each Member appointed to the Medical Staff shall be assigned to have Clinical Privileges in a Department and Service, if applicable.

6.1.2 The Department of Medicine includes the following Services:

A. Emergency Medicine
B. Family Practice
C. Internal Medicine
D. Neurology/Psychiatry
E. Pediatric
F. Radiology

6.1.3 The Department of Surgery includes the following Services:

A. Anesthesiology
B. Dental and Oral Maxillofacial
C. Otolaryngology

D. General Surgery
E. Neurosurgery
F. OB/GYN
G. Ophthalmology
H. Orthopedic
I. Pathology
J. Trauma
K. Urology

6.1.4 When appropriate, the Executive Committee may recommend to the Board the creation, elimination, modification, or combination of Services. Any three (3) active Members of the same specialty, who are not currently represented as a Service may submit a request to the Executive Committee that a Service be formed. The Executive Committee may take any one of the following actions in response to such a request: approve, deny, table for additional information, or refer resolution of the question to the general Medical Staff. Where the Executive Committee denies the request to form a new Service, the concerned Members may appeal that decision to the general Medical Staff, whose decision shall be final.

6.1.5 Sections may be formed within Services upon the unanimous request of all Members of a sub-specialty for the purpose of providing a forum to discuss issues of common interest and importance to the specialty. The request must be approved by the unanimous vote of the Members of the Service. Sections so formed shall not have a formal structure or chair. A section shall have no formal authority and shall serve solely in an advisory capacity, the sole activities of a section being limited to advising the Service Chair on basic requirements for initial appointment and reappointment of sub-specialists seeking appointment to the Medical Staff and Clinical Privileges equivalent to those held by other Members of the section; recommending specific performance improvement activities pertinent to the Members of the section to responsible Medical Staff committees; and advising the Service Chair as to special needs of the section. All activities of the section shall be reported to the Service Chair.

6.2 Duties of Departments

6.2.1 The general functions of each Department shall include:

A. Serving as a forum for the exchange of clinical information regarding services provided by Members of the Department;

B. Providing information and/or recommendations, when requested, to the Department chair and/or Executive Committee related to:

1. Medical Staff Rules and Regulations that concern the conduct of clinical care activities within the Department;

2. issues of standards of practice and/or clinical competence;

3. evaluation of provisional Members;

4. guidelines and criteria for the grant of Clinical Privileges and the performance of specified services within the Department;

5. the qualifications of Applicants seeking appointment or reappointment and Clinical Privileges within the Department;

6. criteria for granting clinical privileges to Allied Health Professionals and the qualifications of Applicants seeking appointment and reappointment to the Allied Health Staff; and

7. scheduling and responsibility of Members for emergency call coverage.

C. Conducting periodic patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Department and to identify opportunities to improve patient care and safety.

D. Recommending to the Executive Committee appropriate additions and revisions to Department-specific Rules and Regulations or policies;

E. Conducting, participating and making recommendations regarding continuing education programs pertinent to Department clinical practice;

F. Meeting at least monthly or more often if necessary to conduct the business of the Department, it being acceptable to combine and concurrently hold meetings of the Department with those of the general Medical Staff;

G. Submitting written reports to the Executive Committee concerning:

1. the Department's review and evaluating activities, actions taken thereon, and the results of such action; and
2. recommendations for maintaining and improving the quality of care provided in the Department and Washington Regional;

H. Taking appropriate action when issues involving clinical performance or opportunities to improve care are identified;

I. Accounting to the Executive Committee for all professional and Medical Staff administrative activities within the Department.

6.3 Department Chair and Vice Chair

6.3.1 **Department Leadership**. Each Department shall have a chair and vice-chair to be elected by the Active Members of the Department.

6.3.2 **Qualifications**. Each Department chair and vice chair shall be a Member in good standing of the Active Medical Staff who has demonstrated a high level of clinical competency and held appointment to the Active category for a period of not less than five (5) years at the time of their nomination. Each Department chair and vice chair must have board certification in their specialty.

6.3.3 **Election of Department Leadership**.

A. At the annual meeting of the general Medical Staff held in odd-numbered years each Department shall elect a vice chairman.

B. The Departmental Nominating Committee shall prepare a slate of nominees from the membership of the Department who meet the qualifications for office outlined in Section 6.3.2 and submit the same to the Department chair no later than sixty (60) days prior to the general Medical Staff meeting at which the election shall take place. The Department chair shall ensure that written notification of the nominees for vice chair is submitted to the Members of the Department, together with notice as to the date, time and location of the general Medical Staff Meeting, no later than thirty (30) days prior to the date of the general Medical Staff Meeting. No nominations will be accepted from the floor, though written petitions proposing nominees may be submitted to the Departmental Nominating Committee. The vice chair shall be elected by a simple majority of the votes cast. If there are more than two nominees and no nominee receives a majority of the votes cast on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

6.3.4 **Term**. The Department chair and Department vice chair shall each serve two (2) year terms and until such time as a successor is elected. The Department vice chair shall automatically ascend to the office of Department chair upon conclusion of the chair's term, or where the chair position becomes vacant as result of removal, resignation, death, disability or other reason. Where the Department vice chair completes the balance of any unexpired term of a Department chair, the vice chair shall continue as the Department chair for an additional two year term.

6.3.5 **Removal**. Removal of a Department chair or vice chair during his term of office may be effected by a two-thirds (2/3) majority vote of the Active Members of the Department at a meeting of the Department at which a quorum is present. No such removal shall be effective unless and until it has been ratified by the Executive Committee. A majority vote of the Executive Committee is required to sustain the removal recommendation of the Department. A Department chair or vice chair may be removed from office for any valid cause, including, but not limited to, failure to carry

out the duties of the office or gross neglect or malfeasance in office. No procedural rights shall exist for any such removal, including the provisions of Article IX of these Bylaws.

6.3.6 **Vacancies**. Except as otherwise provided in these Bylaws, a vacancy in the Department crechair or vice chair position, whether resulting from removal, resignation, death, disability or otherwise, shall be filed in the manner specified in this Section 6.3.6. An ad hoc nominating committee comprised of three (3) Members of the Department shall be appointed by the first of the following Medical Staff leaders still in office: Department chair, Department vice chair, Chief of Staff, or Vice Chief of Staff. As promptly as possible, but in no event more than thirty (30) days after such appointment, the ad hoc nominating committee shall prepare a slate of nominees from the membership of the Department who meet the qualifications for office outlined in Section 6.3.2 of these Bylaws and submit the same to the Chief of Staff. The Chief of Staff shall promptly schedule a special Department meeting to be held within forty-five (45) days of the Chief of Staff's receipt of the ad hoc committee's slate of nominees and deliver written notice of the date, time and place of the special Department meeting, together with a written agenda describing the purpose of the meeting and identifying the slate of nominees proposed for election to the open Department position(s), to each Active member of the Department. No nominations will be accepted from the floor, though written petitions proposing nominees may be submitted to the ad hoc nominating committee. The chair or vice chair shall be elected by a simple majority of the votes cast. If there are more than two nominees and no nominee receives a majority of the votes cast on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

6.4 Duties of Department Chair

6.4.1 Each Department Chair has the following responsibilities:

A. report to the Executive Committee regarding all professional and administrative activities within the Department including the quality of patient care rendered by Members of the Department;

B. develop and implement Departmental programs to review credentials and Privileges, medical education, concurrent monitoring of practice and other quality improvement functions as required by these Bylaws, and as are necessary to assure that the quality of patient care provided within the Department is regularly monitored, assessed and reported.

C. act as presiding officer at Departmental meetings and provide its Members with information on administrative and Medical Staff matters, performance improvement and peer review activities, policy and procedure development, patient care and other concerns.

D. serve as a voting member of the Executive Committee, give guidance on the

overall medical policies of the Medical Staff and Washington Regional, and make specific recommendations regarding the Department;

E. continuously review the professional performance of all Members and Allied Health Professionals with Clinical Privileges in the Department;

F. forward the Department's recommendations concerning criteria for Medical Staff appointment and reappointment, delineation of Clinical Privileges, new procedures, or specific services, and disciplinary action with respect to Members in the Department;

G. appoint such advisory committees as are necessary to conduct the functions of the Department and designate a chair for each;

H. enforce the Bylaws, Rules, and Regulations within the Department, including the initiation of disciplinary action and investigation of clinical performance where warranted;

I. communicate and implement Executive Committee actions in the Department;

J. recommend resources needed within the Department; and

K. perform such other duties as may from time to time be reasonably requested by the Chief of Staff, the Executive Committee, the Administrator, or the Board.

6.5 Duties of Department Vice Chair

6.5.1 Each vice chair shall perform such duties as are assigned to him under these Bylaws or the Department chair and shall assume the chair's duties and authority during the absence of the chair.

6.6 Duties of Services

6.6.1 The general functions of each Service shall include:

A. Serving as a forum to review clinical aspects of care related to the Service;

B. Reviewing and approving, on a biannual basis, Service specific:

1. rules and regulations;

2. Clinical Privileges; and

3. criteria for delineating and granting clinical privileges to Allied Health Professionals;

C. Providing information and/or recommendations, when requested, to the Department chair related to Service specific:

1. rules and regulations;

2. quality assessment and performance improvement activities;

3. peer review activities;

4. Clinical Privileges;

5. evaluation of provisional Members; and

6. the qualifications of Service Members for appointment and reappointment to the Medical Staff.

6.7 Service Chair

6.7.1 **Service Leadership**. Each Service shall have a chair to be elected by the Active Members of the Service.

6.7.2 **Qualifications**. Each Service chair shall be a Member in good standing of the Active Medical Staff who has demonstrated a high level of clinical competency and holds appointment to the Active category of the Medical Staff at the time of their nomination. Each Service chair must have board certification in their specialty.

6.7.3 **Election of Service Chair**.

A. At the annual meeting of the general Medical Staff held in odd-numbered years each Service shall elect a chair from the Members comprising the Service.

B. Only Members of the Active category of the Medical Staff shall be permitted to nominate or vote for a Service chair. Any Member meeting the qualifications set forth in Section 6.7.2 of these Bylaws who wishes to be considered for the position of Service chair shall advise the Department chair in writing no later than ninety days before the general Medical Staff meeting in an odd-numbered year of his/her qualifications and desire to be a candidate for the Service chair position. The Department chair shall ensure that written notification of the candidates for Service chair is submitted to the Members of the Service, together with notice as to the date, time and location of the general Medical Staff Meeting, no later than sixty (60) days prior to the date of the general Medical Staff Meeting. Nominations for the Service chair position will also be accepted from the floor. The Service chair shall be elected by a simple majority of the votes cast. If there are more than two nominees and no nominee receives a majority of the votes cast on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

6.7.4 **Term**. Each Service chair shall serve a two (2) year term and until such time as their successor is elected. A Service chair may be re-elected to serve consecutive terms.

6.7.5 **Removal**. Removal of a Service chair during his term of office may be effected by a majority vote of the Active Members of the Service at a meeting of the Service at which a quorum is present. No such removal shall be effective unless and until it has been ratified by the Department of which the Service is a part. A majority vote of the Department is required to sustain the removal recommendation of the Service. A Service chair may be removed from office for any valid cause, including, but not limited to, failure to carry out the duties of the office or gross neglect or malfeasance in office. No procedural rights shall exist for any such removal, including the provisions of Article IX of these Bylaws.

6.7.6 **Vacancies**. A vacancy in the Service chair position, whether resulting from removal, resignation, death, disability or otherwise, shall be filed by the Department chair who shall appoint a qualified Member from the Service to serve as the interim Service chair until a successor can be elected at the next general Medical Staff meeting utilizing the procedures outlined in Section 6.7.3.B of theses Bylaws.

6.8 Duties of Service Chair

6.8.1 Each Service Chair has the following responsibilities:

A. acting as the presiding officer at Service meetings and serving as a voting member of the Departmental Control Committee;

B. being generally responsible for the supervision of medical and administrative functions of the Service, ensuring the ongoing, effective operations of the Service, and generally monitoring the quality of patient care and professional performance rendered by Members with Clinical Privileges in the Service, and overseeing the patient care, practitioner evaluation, and monitoring functions delegated to the Service by the Department;

C. being responsible for determining and recommending the qualifications and competence of all Medical Staff Members and Allied Health Professionals who render care within the Service;

D. forwarding to the Credentials Committee the Service's recommendations concerning initial Medical Staff membership and reappointment of all Members and Allied Health Professionals who render care within the Service;

E. enforcing the Medical Staff Bylaws, Rules and Regulations, including making recommendations or providing information to the Department chair, Chief of Staff, and/or Executive Committee with regard to professional review actions that have been recommended or have been imposed with respect to any Member of the Service;

F. establishing criteria, consistent with these Bylaws and the policies of the Medical Staff, for the granting of Clinical Privileges within the Service;

G. being responsible for communication of clinical and administrative matters within the Service and to and from the Department;

H. being responsible for implementing within the Service actions taken by the Department;

I. being directly accountable to the Department chair for the quality of care rendered to each patient admitted to the Service;

J. recommending resources needed within the Service;

K. where requested by the Physician Peer Review Committee, performing reviews of the care provided by individual Members within the Service and providing findings and recommendations concerning the same to the Physician Peer Review Committee; and

L. performing such other duties as may from time-to-time be reasonably requested by the Department Chair, the Chief of Staff, or the Executive Committee.

6.9 Chief of Staff, Chair Leave of Absence

6.9.1 Any Member serving as Chief of Staff, Vice Chief of Staff, Department Chair or Service Chair who requests or takes a leave of absence shall be deemed to have resigned their Medical Staff leadership position.

ARTICLE VII

OFFICERS

7.1 Officers

The officers of the Medical Staff shall be the Chief of Staff, the Vice Chief of Staff, and the Immediate Past Chief of Staff.

7.2 Qualifications of Officers

7.2.1 Officers must be Members of the Active Medical Staff for a period of not less than ten (10) years at the time of their nomination and election and must thereafter remain a Member of the Active Medical Staff in good standing throughout their term of office. Failure to maintain such status shall result in the immediate removal from office of the concerned Member.

7.2.2 No active Member who is an owner, employee, trustee, director or officer of a hospital, medical staff, or other health system other than Washington Regional may be nominated,

elected or hold office.

7.3 Election of Officers

7.3.1 Officers shall be elected at the annual meeting of the Medical Staff in odd- numbered calendar years.

7.3.2 The nominating committee shall prepare a slate of officers as provided in Article XII of these Bylaws. No nominations will be accepted from the floor.

7.3.3 Officers shall be elected by a simple majority of the votes cast. If there are more than two nominees and no nominee receives a majority of the votes cast on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

7.4 Term of Office

7.4.1 The Chief of Staff, Vice Chief of Staff, and Immediate Past Chief of Staff shall each serve two (2) year terms and until such time as a successor is elected.

7.5 Duties of Officers

7.5.1 The responsibilities of the Chief of Staff or his designee shall include, but not be limited to:

A. Working in a collaborative manner with the Administrator and Board of Directors in all matters of mutual concern within Washington Regional;

B. Calling and presiding at all meetings of the Medical Staff and the Medical Executive Committee, and being responsible for the agenda of all meetings thereof;

C. Serving as Chairman of the Medical Executive Committee;

D. Serving as a non-voting, ex-officio member of all other Medical Staff committees, unless these Bylaws specifically provide to the contrary;

E. Having principal responsibility for enforcing the Medical Staff Bylaws, Rules, and Regulations; implementing sanctions when indicated; and ensuring compliance with procedural safeguards where corrective action has been recommended and/or implemented against a Member;

F. Appointing the members of all Medical Staff committees and designating the chairs of the committees, except as otherwise provided for by these Bylaws;

G. Receiving and interpreting the policies of the Board on performance improvement and maintenance of quality with respect to Medical Staff's delegated responsibility to provide medical care;

H. Being responsible for the educational activities of the Medical Staff;

I. Being a spokesman for the Medical Staff in external professional and public relations;

J. Performing oversight of Medical Staff clinical activities within Washington Regional, including quality improvement, credentialing and privileging, patient safety, and utilization management consistent with the Medical Staff's delegated responsibility to ensure the provision of appropriate professional care to Washington Regional's patients; and

K. Performing such other functions as may be assigned to him/her by these Bylaws, the Medical Staff, or by the Medical Executive Committee;

7.5.2 The Vice Chief of Staff shall:

A. Assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff or upon his disqualification or recusal;

B. Serve as a voting Member on the Medical Executive Committee;

C. Perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee;

D. Serve as a non-voting, ex-officio member of all other Medical Staff committees, unless these Bylaws specifically provide to the contrary; and

E. Succeed to the office of Chief of Staff upon completion of his two (2) year term of vice chief of staff.

7.5.3 The Immediate Past Chief of Staff Shall:

A. Assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff and the Vice Chief of Staff or upon their disqualification or recusal;

B. Serve as a voting Member on the Medical Executive Committee;

C. Perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee; and

D. Serve a two (2) year term as a voting member of the Washington Regional Board of Directors.

7.6 Vacancies in Office

7.6.1 If there is a vacancy in the office of the Chief of Staff prior to the expiration of his term, succession shall occur as follows:

A. If a vacancy occurs during the first year the Chief of Staff is in office, the Immediate Past Chief of Staff will serve out the remainder of the first year and the Vice Chief of Staff will serve the second year of that term and then his two year term;

B. In the event neither the Vice Chief of Staff nor the Immediate Past Chief of Staff is able to succeed to the vacant position, the Executive Committee shall appoint a Member of the active Medical Staff who meets the qualifications set forth in Section 7.2 of these Bylaws to fill the vacant position. Members who have previously served as Chief of Staff are eligible for appointment;

C. The identity of the successor Chief of Staff shall be communicated to the Medical Staff within three (3) days; and

D. The appointment shall be ratified by the general Medical Staff at its next meeting.

7.6.2 If there is a vacancy in the office of Vice Chief of Staff prior to expiration of his term, succession shall occur as follows:

A. If a vacancy occurs during the first year the Vice Chief of Staff is in office, the Immediate Past Chief of Staff will serve as the interim Vice Chief of Staff until the next meeting of the general Medical Staff, at which time a successor shall be elected;

B. The Nominating Committee shall promptly proceed to select a slate of nominees and communicate the same to the general Medical Staff in accordance with the procedures set forth in Section 7.3.2 and Section 12.9.3 of these Bylaws. The general Medical Staff shall thereafter elect a successor Vice Chief of Staff in accordance with the procedure set forth in Section 7.3.3 of these Bylaws.

7.7 Removal of Officers

7.7.1 An elected officer may be removed from office for any valid cause, including, but not limited to, failure to perform the duties of the office, engaging in conduct detrimental to the interests of the Medical Staff or Washington Regional, gross neglect or misfeasance in office, or one or more serious acts of moral turpitude.

7.7.2 Except as otherwise provided, a 2/3 vote of the Medical Executive Committee or a petition signed by at least 1/3 of the Members eligible to vote for officers is needed to initiate the removal of a Medical Staff officer. Fifteen days notice must be provided to all eligible Members advising that a special meeting of the Medical Staff will be held to consider removal of an officer and which states the date, time and place for such special meeting. Removal of an officer requires a 2/3 majority vote of the Members eligible to

vote for Medical Staff officers and actually voting at the special meeting of the Medical Staff. Voting may be in person or by electronic or written ballot, as determined by the Medical Executive Committee, but all electronic or written ballots must be received by the date and time of the special meeting of the Medical Staff.

7.7.3 The officer in question must be provided with a copy of the written notice described in Section 7.7.2 above, as well as a written statement setting forth the reasons for the proposed action. The officer shall be afforded an opportunity to make a presentation to the general Medical Staff prior to the close of voting on the removal action question.

7.7.4 An officer who fails to continuously meet the qualifications set forth in Section 7.2 of these Bylaws shall automatically be removed from office without necessity of any action on the part of the Medical Staff.

7.7.5 A vacancy in office due to removal of an officer, or a vacancy for any reason, will be filled in accordance with the procedures set forth in Section 7.6 of these Bylaws.

ARTICLE VIII

CLINICAL PRIVILEGES

8.1 Exercise of Privileges

Except as otherwise provided in these Bylaws, a Physician providing clinical services at Washington Regional shall be entitled to exercise only those Clinical Privileges specifically granted by the Washington Regional Board of Directors. Clinical Privileges shall be specific to Washington Regional, within the scope of any license, certificate or other legal credential authorizing practice in the State of Arkansas and consistent with any restrictions thereon, and shall be subject to the Bylaws, Rules and Regulations of the Medical Staff. Duties delegated by a Physician may be performed by an individual authorized to practice a health occupation to the extent that the duty is permitted under applicable law, including those rules, regulations and orders promulgated by the Arkansas State Medical Board or other Arkansas state board or agency that regulates such health occupation.

8.2 Delineation of Clinical Privileges in General

8.2.1 **Requests**. Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the Applicant. A request by a Physician for a modification of Clinical Privileges may be made at any time, but such request must be supported by documentation of training and experience that supports the request. Such request for modification of Clinical Privileges shall be processed in the same manner as an initial application for appointment to the Medical Staff.

8.2.2 **Basis for Clinical Privilege Determination**. A request for Clinical Privileges shall be evaluated on the basis of the Physician's education, training, experience, demonstrated

professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Clinical Privileges take into consideration site-specific criteria. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where the Physician exercises clinical privileges.

8.3 Delineation of Clinical Privileges for New Procedures

A. Where a request for a clinical privilege is submitted for a new technology, to perform either a significant procedure not currently being performed at Washington Regional or a significant new technique to perform an existing procedure, or involving a cross-specialty privilege for which no criteria have been established (hereafter the "new procedure"), the request will be tabled for a reasonable period, usually not to exceed one hundred twenty (120) days, and will not be processed until (1) a determination has been made that the new procedure will be offered by Washington Regional and (2) clinical privilege criteria necessary to establish the qualifications to perform the new procedure have been established.

B. The Credentials Committee and MEC will make a preliminary recommendation to the Board as to whether the new procedure should be offered to the community. Factors to be considered in developing this recommendation include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at hospitals similar to Washington Regional and the experiences of those institutions, whether the new procedure is approved for use in the particular acute care hospital setting under consideration by applicable regulatory authorities, and whether Washington Regional has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure. The Credentials Committee and MEC shall meet with Washington Regional management to ensure that the new procedure is consistent with Washington Regional's mission, values, strategic, operating, capital, information system and staffing plans and budgets.

C. If it is recommended that the new procedure be offered at Washington Regional, the Credentials Committee will conduct research and consult with subject matter experts, including those on the Medical Staff and those outside of Washington Regional, to compile information relevant to the privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate. On the basis of such research, the Credentials Committee shall develop recommendations regarding (1) the minimum education, training and experience necessary to perform the new procedure, and (2) the extent of proctoring, monitoring or supervision, if any, that should occur if the clinical privileges are

granted including who may serve as a proctor and how many proctored cases will be required. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate.

D. If the clinical privileges requested for the new procedure will overlap two or more specialty disciplines, an ad hoc committee will be appointed by the Chairperson of the Credentials Committee to recommend criteria for the privileges under consideration. The ad hoc committee will consist of at least one, but not more than two, Members from each involved discipline. The chair of the ad hoc committee will be a member of the Credentials Committee who has no vested interest in the issue. Recommendations of the ad hoc committee shall be presented to the Credentials Committee for use and consideration by the Credentials Committee and MEC in formulating their respective recommendations regarding the proposed clinical privileges for the new procedure.

E. The Credentials Committee will forward its recommendations regarding the need for the new procedure and, if applicable, the proposed criteria for clinical privileges associated with the new procedure to the MEC, which will review the matter and forward its recommendations to the Board for final action. Requests for specific clinical privileges to perform the new procedure may only be processed and considered after the Board has (1) affirmatively concluded that there exists a need for the new procedure at Washington Regional and (2) approved the specific clinical privileges applicable to the performance of that new procedure at Washington Regional.

8.4 Categories of Temporary Clinical Privileges

Washington Regional recognizes three (3) categories of temporary clinical privileges: Emergency Privileges, Disaster Privileges, and Temporary Privileges.

8.4.1 Emergency Privileges

In the case of emergency, any Member, to the degree permitted by his or her license and regardless of Medical Staff Service, Medical Staff category, or Clinical Privileges, shall be permitted to do, and shall be assisted by Washington Regional personnel in doing everything possible to save a patient from such danger. When the emergency situation no longer exists, such Member must request the clinical privileges necessary to continue to treat the patient. In the event such clinical privileges are not obtained, the patient shall be assigned to a Member with appropriate Clinical Privileges. For the purpose of this section, an "emergency" is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death and any delay in administering treatment would add to that danger.

8.4.2 Disaster Privileges

The purpose of this section is to provide a process to credential Physicians, Dentists and Allied Health Professionals who are not members of the Medical or Allied Health Staffs and who do not possess Clinical Privileges but who may provide patient care services during a disaster (defined as an officially declared emergency, whether it is local, state, or national). The following process shall govern the grant, continuation and termination of Disaster Clinical Privileges at Washington Regional:

A. Where the Washington Regional Emergency Operations Plan ("Disaster Plan") has been activated and Washington Regional is unable to meet immediate patient care needs, the Administrator and such other individuals as are identified in the Disaster Plan with such authority, may, on a case-by-case basis consistent with medical licensing and other relevant Arkansas law, grant disaster privileges to provide patient care to Physicians, Dentists and Allied Health Professionals who must, at a minimum, present 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. A current picture hospital identification card that clearly identifies professional designation;
2. A valid professional license to practice issued by a state licensing authority located within the United States of America;
3. Primary source verification of the license;
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups.
5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);
6. Identification by a current hospital or medical staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed Physician, Dentist or Allied Health Professional during a disaster.

B. The Medical Staff oversees the professional performance of volunteer Physicians, Dentists and Allied Health Professionals who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The Medical Staff shall make a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the Disaster Clinical Privileges initially granted.

C. Primary source verification of licensure shall begin as soon as the immediate situation that resulted in the invocation of the Disaster Plan is under control, and shall be completed within 72 hours from the time the volunteer practitioner

presents to Washington Regional. The following information shall be provided to the Medical Staff Office as soon as possible:

1. Certificate of malpractice insurance;
2. List of current hospital affiliations where the Physician, Dentist or Allied Health Professional holds a current medical or allied health staff appointment and clinical privileges;
3. Documentation gathered by the executive granting Disaster Clinical Privileges reflecting the date and time the request for Disaster Clinical Privileges was made, together with the individual's state license number and expiration date.

D. Where extraordinary circumstances preclude primary source verification from occurring within 72 hours of the volunteer practitioner presenting to Washington Regional, the Medical Staff Office will document:

1. The reason that the primary source verification could not be completed within the 72 hour time frame;
2. The means used by Washington Regional to evaluate the competency and qualifications of the volunteer practitioner; and
3. The efforts made by the Medical Staff Office to conduct primary source verification as soon as possible.

E. A practitioner granted Disaster Clinical Privileges shall at all times wear a badge issued by the responsible WRMC executive that clearly identifies the practitioner as having "Disaster Clinical Privileges Only".

F. Once the immediate situation that resulted in the invocation of the Disaster Plan has passed and such determination has been made in accordance with the Disaster Plan, the practitioner's Disaster Clinical Privileges shall terminate immediately.

G. Any individual identified in the Disaster Plan as having authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the Washington Regional executives charged with the authority to extend disaster privileges, and the exercise of such right shall not give rise to any right on the part of a practitioner granted Disaster Clinical Privileges to a fair hearing or an appeal pursuant to these Bylaws.

8.4.3 Temporary Privileges

A. The Administrator acting on behalf of the Board of Directors and based on the recommendation of the applicable Service Chairman, Department Chairman, and Chief of Staff may grant Temporary Privileges provided the Medical Staff Office is able to verify the Physician's current licensure and competence. Temporary Privileges may only be granted in two circumstances:

1. to fulfill an important patient care, treatment, or service need; or
2. when an initial Applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and Board. A complete initial Application raises no concerns where it has been classified as a Type I application as described in Section 4.6.1.A of these Bylaws.

B. Important Patient Care, Treatment or Service Need. Temporary Privileges may be grated on a case-by-case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed one hundred twenty (120) calendar days, while the full credentials information is verified and approved. For the purposes of granting Temporary Privileges, an important patient care, treatment or service need is defined as including:

1. A circumstance in which one or more patients will experience care that does not adequately meet their clinical needs if the Temporary Privileges are not granted;
2. A circumstance in which Washington Regional will be placed at risk of not adequately meeting the needs of patients who seek care, treatment or service from Washington Regional if the Temporary Privileges under consideration are not granted (e.g., Washington Regional will not be able to provide adequate emergency department coverage in the Applicant's specialty, or the Board has granted Clinical Privileges involving new technology to a Physician provided the Physician is precepted for a specific number of initial cases and the preceptor, who is not seeking Medical Staff appointment, requires Temporary Privileges to serve as a preceptor).

Temporary Privileges shall be granted only after the Applicant applying for such privileges has provided the following information and the same is verified by the Medical Staff Office:

1. A complete application for appointment, including a request for specific Clinical Privileges has been received;
2. Verification is completed regarding current Arkansas licensure, DEA registration, relevant training and experience, current competence, and ability to perform the Clinical Privileges requested;
3. Verification has been obtained that the Applicant has the professional liability insurance coverage required under Section 4.4.1.I of these Bylaws;
4. Verification that there are no current or previous successful challenges to licensure or registration;
5. Verification that the Applicant has not been subject to involuntary termination of medical staff membership at another organization;
6. Verification that the Applicant has not been subject to limitation,

reduction, denial or loss of clinical privileges;

7. The National Practitioner Data Bank (NPDB) has been queried;
8. Verification that the Applicant has not been excluded from participation in the Medicare or Medicaid program;
9. Evaluation, regardless of whether the Applicant is a reactor, non-reactor, or converter, in accordance with the applicable requirements set forth in the *Rules Pertaining To: The Control of Communicable Diseases-Tuberculosis* published by the Arkansas Department of Health, together with documented evidence of any other health screening or vaccination that may be required of Physicians practicing within a general hospital under applicable federal or Arkansas law; and
10. A favorable recommendation has been made by the appropriate Department Chairperson.

C. The Chief of Staff in consultation with the Department Chairperson may impose such conditions and restrictions on Temporary Privileges as he deems necessary, including, but not limited to, requirements of consultation, proctoring and restrictions on the number and/or types of patients that may be treated.

D. To receive Temporary Privileges under either of the two circumstances set forth in subsection 8.4.3.A., the Applicant must provide that documentation required under Section 4.5.1 of these Bylaws, which information shall be verified by the Medical Staff Office.

E. Temporary Privileges may be granted for a period not to exceed one hundred twenty (120) days unless such period is extended by the Administrator, in his sole discretion, after consultation with the Chief of Staff.

F. Requests for Temporary Privileges must be submitted to the Medical Staff office in writing at least five (5) working days in advance of the requested effective date, and must meet all the requirements listed in this Section 8.4.3. For purposes of this Section 8.4.3, the term Applicant shall include a Member who currently holds a Medical Staff appointment and clinical privileges and is requesting one or more additional privileges, whether such application is made at the time of reappointment or otherwise.

G. The Administrator, acting on behalf of the Board and after consultation with the Chief of Staff and applicable Department Chairperson, may terminate any or all of a Physician's Temporary Privileges based on discovery of information or an event that raises questions about a Physician's continued exercise of Temporary Privileges. Where the life or well-being of a patient is determined to be endangered, any person entitled to impose a summary suspension under Article IX of these Bylaws may effect the termination. In the event of such a termination, the Physician's patients will be assigned to another Member by the Chief of Staff or his or her designee. A Physician whose Temporary Privileges have been terminated pursuant to this subsection, or whose request for Temporary Privileges

has been denied, shall not be entitled to the procedural rights afforded under Article IX of these Bylaws.

8.5 Dental Privileges

8.5.1 Clinical Privileges granted to Dentists shall be based on their training, experience, demonstrated competence and licensure. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and recommended in the same manner as other Clinical Privileges.

8.5.2 Members who are dentists may admit dental patients to Washington Regional under the jurisdiction of the Surgery Department and shall designate a Physician Member who shall have primary medical responsibility for the patient in the medical record upon admission. All dental patients must have the same basic medical appraisal as patients admitted to other clinical services. The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination related to dentistry. A Physician Member shall be responsible for the medical care of the patient throughout any period of hospitalization.

8.5.3 Dentists may write orders and prescribe medications within the limits of their licensure, the specific Clinical Privileges granted by the Medical Staff, and in compliance with the Medical Staff Bylaws, Rules and Regulations.

8.5.4 Oral surgeons can admit patients without corresponding medical problems, perform a history and physical examination, and assess medical risks associated with the procedure provided they have the Clinical Privileges to do so. Criteria to be used in granting such Clinical Privileges shall include, but shall not necessarily be limited to, successful completion of a postgraduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education, and evidence of current competency. Patients with medical problems admitted to Washington Regional by Members who are oral surgeons shall receive the same basic medical appraisal as patients admitted to other clinical services.

8.6 Telemedicine Privileges

A. Telemedicine is the exchange of medical information via secure, electronic communication between Washington Regional and an external site for the purpose of improving patient care, treatment and services. The Board of Directors shall determine the clinical services to be provided at Washington Regional through telemedicine after considering the recommendations of the appropriate Department Chairperson, the Credentials Committee, and the MEC.

B. Only Physicians who are working through a corporate entity that is engaged by Washington Regional pursuant to the terms of a written service contract may apply for Telemedicine Privileges. Physicians applying for Telemedicine

Privileges shall meet the qualifications for Medical Staff appointment set forth in Section 4.4 of these Bylaws. Physicians holding Telemedicine Privileges will not be eligible for appointment to the Medical Staff. Telemedicine Privileges shall be incident to and coterminous with the written service contract between Washington Regional and the corporate entity through which the Physician provides telemedicine services.

C. Applications for Telemedicine Privileges shall be processed in the same manner as for any other Applicant in accordance with the processes and procedures set forth in Article IV of these Bylaws, except that Washington Regional may utilize and rely upon credentialing and privileging information provided by the Applicant's primary hospital, provided that hospital is located within the State of Arkansas, is accredited by The Joint Commission, and enters into a written agreement with Washington Regional that:

1. Contains an attestation that the Physician holds active clinical privileges for the clinical privileges they are requesting at Washington Regional;
2. Provides that Washington Regional will have access to peer review information and performance data that the primary hospital maintains with respect to the Physician;
3. Requires the primary hospital to promptly notify Washington Regional of any corrective action that it takes against the Physician.

D. Telemedicine Privileges shall be for a period of not more than two (2) years. Physicians seeking to renew Telemedicine Privileges shall be required to complete an application and provide Washington Regional with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the Applicant's primary hospital or practice and evaluation forms from physician peers. If all requested information is not received by dates established by Washington Regional, the Physician's Telemedicine Privileges will expire at the end of the current term.

Physician's granted Telemedicine Privileges will be subject to the Medical Staff's performance improvement, ongoing and focused professional practice evaluations and peer review activities. Washington Regional will conduct quality validation by having a Member of the Medical Staff with equivalent privileges review certain cases (e.g., over- reads of imaging studies), with results to be maintained in the Physician's Medical Staff file.

ARTICLE IX

CORRECTIVE ACTION, HEARING AND APPEAL

9.1 Corrective Action

9.1.1 ***Criteria for Corrective Action.*** The procedures set forth in this Article IX shall be invoked whenever the activities or professional conduct of a Member are, or are reasonably likely to be: detrimental to the safety of any patient, visitor, Member, or employee of Washington Regional; inconsistent with the delivery of patient care at the generally recognized professional level of quality at Washington Regional; lower than the standards or aims of the Medical Staff; disruptive to the operations of Washington Regional; in violation of Washington Regional policies or the Bylaws, Rules and Regulations, or policies of the Medical Staff; or, an impairment to the confidence of the community in Washington Regional.

9.1.2 ***Initiation of Corrective Action***. An officer of the Medical Staff, the Administrator, or the Board may request corrective action on the basis of any of the criteria set forth above. All requests for corrective action shall be made in writing and directed to the Chief of Staff, unless the Chief of Staff has previously determined that corrective action may be warranted, and shall be supported by specific, factual references as to the conduct or activities that constitute the basis for the request for corrective action.

9.1.3 ***Investigative Procedure.***

A. Where a request for corrective action could result in the termination, suspension, or reduction of a Member's Clinical Privileges or Medical Staff appointment, the Chief of Staff shall forward the request to the Chair of the Department to which the affected Member is appointed.

B. Upon receipt of such request, the Department Chair shall immediately appoint an ad hoc investigative committee of not fewer than three (3) Members of the Department to investigate the matter. The ad hoc investigative committee shall have the authority to review all relevant records and reports, interview individuals with knowledge of the matters under investigation, and shall conduct an interview with the affected Member. At such interview the affected Member shall be informed of the general nature of the allegations supporting the request for corrective action and the Member shall have the opportunity to discuss, explain, or refute them. All interviews shall be conducted informally, shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. The Executive Committee, the Chief of Staff, and/or the Departmental ad hoc investigative committee shall have available to it the full resources of Washington Regional and the Medical Staff, as well as the authority to engage outside consultants, if needed.

C. The Departmental ad hoc investigative committee shall submit a written report of its investigation to the Chief of Staff and Medical Executive Committee as soon as practicable but in no event later than fourteen (14) days after the receipt of the request for corrective action. The written report shall include a record of all interviews conducted in the course of the investigation.

D. Upon receipt of the written report prepared by the Departmental ad hoc investigative committee, the Medical Executive Committee shall act as soon as practicable upon the request for corrective action. The Chief of Staff shall call a meeting of the Medical Executive Committee to review the findings of the investigation. If corrective action is proposed which could result in a reduction or suspension of a Member's Clinical Privileges, or a suspension or termination of a Member's appointment to the Medical Staff, the affected Member shall be permitted to make an appearance before the Medical Executive Committee. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. The Medical Executive Committee shall make a written record of such appearance.

9.1.4 ***Executive Committee Action.*** Within fourteen (14) days after the conclusion of the investigation, the Executive Committee shall take one or more of the following actions:

A. Determine that no corrective action is warranted on the basis of the investigation conducted;

B. Direct that additional information be submitted to the Executive Committee;

C. Issue the affected Member a letter of admonition, warning, or reprimand, a copy of which shall be placed in the affected Member's file;

D. Recommend terms of probation or limitation upon the affected Member's continued Medical Staff appointment or exercise of Clinical Privileges including, without way of limitation, requirements for consultation or monitoring in specified cases;

E. Recommend that the affected Member's medical staff appointment and/or Clinical Privileges be reduced, revoked, terminated or suspended for a designated period (other than a summary suspension);

F. Recommend that a summary suspension of Clinical Privileges be terminated, modified, or sustained.

The recommendation of the Medical Executive Committee shall be contained in a brief report to the Board, which shall contain a statement of the grounds supporting the

recommendation. The affected Member shall be provided a copy of such recommendation, along with information regarding the affected Member's hearing and appeal rights, if applicable, as required pursuant to Section 9.4.1 of these Bylaws.

9.1.5 ***Procedural Rights***. Any recommendation of the Medical Executive Committee pursuant to Sections 9.1.4(d), (e), or (f) shall entitle the affected Member to the procedural rights as provided in Part 9.4. Failure of the affected Member to timely request a hearing in accordance with the procedures set forth in Part 9.4 shall be deemed a waiver of his right to a hearing and the recommendation of the Executive Committee shall be forwarded to the Board for action pursuant to Section 9.1.6(a).

9.1.6 ***Governing Board Action.***

A. At its next regular meeting after receipt of the Medical Executive Committee's report, the Board shall take final action on the matter unless the affected Member has requested a hearing in accordance with Part 9.4 of these Bylaws, in which event no action shall be taken until the matter is submitted to the Board upon conclusion of the hearing and appellate review process. If the Medical Executive Committee's recommendation did not entitle the affected Member to a hearing, but the action of the Board would entitle the affected Member to a hearing had that action been taken by the Medical Executive Committee, or if the corrective action announced by the Board is more restrictive than the action recommended by the Medical Executive Committee, and such action, if taken by the Medical Executive Committee, would have entitled the affected Member to a hearing, then the Chairman of the Board shall promptly notify the affected Member in writing of his right to a hearing in accordance with Part 9.4 of these Bylaws. In no event, however, shall the affected Member be entitled to more than one hearing.

B. If the Board determines that the Medical Staff has failed to act in a timely fashion in processing and recommending action on a request for corrective action, the Board may, after notifying the Medical Executive Committee of its intent and designating an action date prior to which the Medical Executive Committee may still act, take action on its own initiative. If such action would have entitled the affected Member to a hearing had that action been taken by the Medical Executive Committee, then the Chairman of the Board shall promptly inform the affected Member in writing that he is entitled to a hearing in accordance with Part 9.4 of these Bylaws, unless the affected Member has previously had a hearing or waived the right of h earing.

9.2 Summary Suspension

9.2.1 ***Criteria for Initiation.*** The Chief of Staff, the Medical Executive Committee, Board, or the Administrator shall have the right to request that the Chief of Staff or appropriate Department Chairman summarily suspend all or any portion of the Clinical Privileges

of a Member whenever there is reasonable cause to believe that the activities or professional conduct of the Member necessitate immediate action to protect the life, health, or safety of any patient or to reduce the likelihood of imminent danger to the life, health or safety of any individual. Such summary suspension shall become effective immediately upon imposition.
Written notice of the suspension, containing a brief statement of the grounds for suspension, shall be provided to the affected Member. The final judgment on such action shall be the responsibility of the Chief of Staff until the Medical Executive Committee has acted upon the matter as provided in Section 9.2.2.

9.2.2 ***Medical Executive Committee Action***. Within fourteen (14) days after the imposition of the summary suspension, the Medical Executive Committee shall review the appropriateness of the summary suspension and shall either continue, modify or terminate the summary suspension. The affected Member shall be entitled to be present, and permitted to present a statement as to why the suspension should be terminated or modified. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. If, at the conclusion of the initial review of the summary suspension, the Medical Executive Committee does not recommend immediate termination of the summary suspension, the affected Member shall be entitled to the hearing and appeal rights set forth in Part 9.4 of these Bylaws. The Chief of Staff shall report the action of the Medical Executive Committee with respect to the summary suspension to the Board at its next regular meeting. The Board shall consider the suspension and shall either continue, modify or terminate the suspension. The terms of the summary suspension as affirmed or established by the Medical Executive Committee shall remain in effect pending final action thereon by the Board.

9.2.3 ***Continuity of Patient Care***. Immediately upon imposition of a summary suspension, the Chief of Staff, responsible Department Chair, responsible Service Chair, or their designees, shall have the authority to provide for substitute medical coverage for the patients of the suspended Member who are inpatients at Washington Regional at the time of such suspension. The wishes of the patient shall be considered where feasible in the selection of such substitute Member(s). The suspended Member shall confer with such substitute Member(s) to the extent necessary to ensure continuity of sound patient care.

9.3 Automatic Suspension

9.3.1 Licensure and DEA Registration.

A Member shall at all times maintain a valid, unrestricted and unencumbered license to practice in the State of Arkansas. In the event the Member's license is revoked, stayed, restricted, encumbered, suspended, or the Member receives notice from any regulatory authority of the suspension, revocation or probation of any license, he shall immediately notify the Chief of Staff who shall initiate review of the Member's status.

A. **Revocation**. Whenever a Member's license to practice in the State of Arkansas, and/or Drug Enforcement Administration registration to prescribe controlled substances are revoked, the Member's Medical Staff appointment and clinical privileges shall be automatically and immediately revoked, without any right to a hearing or appeal, as set forth in these Bylaws. All action taken by the Executive Committee must be presented in the minutes for review and approval at the next regularly scheduled meeting of the Executive Committee.

B. **Suspension**. Whenever a Member's license to practice in the State of Arkansas, and/or Drug Enforcement Administration registration to prescribe controlled substances is suspended, the Member's Medical Staff appointment and Clinical Privileges shall be automatically and immediately suspended, without any right to a hearing or appeal, as set forth in these Bylaws.

C. **Probation**. Whenever a Member's license to practice in the State of Arkansas, and/or Drug Enforcement Administration registration to prescribed controlled substances is encumbered, restricted, or placed on stayed or other probationary status by the applicable licensing authorities, corrective action shall be automatically instituted pursuant to Part 9.1 of the Medical Staff Bylaws.

9.3.2 ***Professional Liability Insurance.*** Whenever a Member fails to maintain evidence of professional liability insurance on such terms and in such amounts as are required pursuant to Article 4, Section 4.4.1.I of the Medical Staff Bylaws, the Member's Clinical Privileges shall be automatically and immediately suspended, without any right to a hearing or appeal, as set forth in these Bylaws, until such time as the Member provides satisfactory evidence of current coverage in accordance with the requirements of these Bylaws together with evidence of tail or retroactive coverage for the period during which such coverage had lapsed or been canceled.

9.3.3 ***Exclusion From Federally Funded Healthcare Programs***. A Member who is excluded from participation in any Federally funded healthcare program, such as Medicare, Medicaid, or Tricare, shall be automatically and immediately suspended, without any right to a hearing or appeal, as set forth in these Bylaws, until such time as the Member provides satisfactory evidence that the terms and conditions of such exclusion are no longer applicable or in effect.

9.3.4 ***Medical Records***. Whenever a Member violates the Medical Staff medical records completion requirements set forth in the Medical Staff Rules and Regulations, the Member's admitting and consulting privileges shall be automatically and immediately suspended, without any right to a hearing or appeal, as set forth in these Bylaws, until such time as the Member completes the medical record deficiencies.

9.3.5 ***Felony/Misdemeanor Indictment or Conviction.*** A Member who has been convicted of, or pled "guilty" or "no contest" or its equivalent to a felony or to a misdemeanor involving a charge of moral turpitude (wrongful or depraved conduct) in any jurisdiction shall be automatically and immediately suspended, without any right to a hearing or

appeal, as set forth in these Bylaws. When charges are filed against a Member, the Medical Executive Committee will review the circumstances to determine if immediate suspension is warranted which, where such action is imposed, shall entitle the Member to the procedures set forth in Section 9.2 of these Bylaws.

9.4 Hearing

9.4.1 ***Grounds for Hearing.*** Except as provided otherwise in these Bylaws, any of the following actions or recommended actions shall constitute grounds for a hearing before an ad hoc committee of the Medical Staff:

A. Denial of initial medical staff appointment or reappointment.

B. Denial or reduction of Clinical Privileges in connection with initial appointment or reappointment.

C. Any action that gives right to a hearing pursuant to Section 9.1.4 (d), (e), or (f).

D. No other circumstances, other than those listed above in (a) through (c), will give rise to a right to a hearing.

9.4.2 ***Notice to Member***. In any case where a Member is entitled to a hearing, the Member shall be provided written notice, by personal delivery or certified mail, return receipt requested, stating:

A. That an adverse recommendation or decision has been made; B.

The reasons for the proposed action;

C. That the Member has a right to request a hearing with respect to the proposed action;

D. That any request for a hearing must be made within thirty (30) days of the Member's receipt of the notice; and

E. A summary of the Member's rights in the hearing.

9.4.3 ***Request for Hearing***. Within thirty (30) days after receipt of the notice described in Section 9.4.2, the affected Member may request a hearing by notifying the Chief of Staff in writing, such request to be delivered personally or by certified mail, return receipt requested. If a Member does not request a hearing within the time and in the manner specified, he shall be deemed to have waived his right to a hearing, and the matter shall be forwarded to the Governing Board for action. If a hearing is requested in accordance with this Section 9.4.2, the hearing shall be held before an ad hoc committee of the Medical Staff as provided in Section 9.4.4.

*9.4.4 **Appointment of Ad hoc Hearing Committee***

A. Within fifteen (15) days of receipt of a request for hearing, the Chief of Staff shall appoint an ad hoc hearing committee comprised of not fewer than five (5) Members of the Medical Staff, one of whom shall be designated Chair. Knowledge of the matter involved shall not preclude a Member from serving on the ad hoc hearing committee, but a Member who has formally participated in the investigation or consideration of the matter shall not be eligible. In the event it is not practicable to appoint an ad hoc hearing committee comprised entirely of Members of the Medical Staff, the Chief of Staff may appoint licensed physicians from outside the Medical Staff. No Member appointed to the ad hoc hearing committee shall be in direct economic competition with the affected Member.

B. The affected Member shall have the right to object to the composition of the ad hoc hearing committee. Any such objection shall be made in writing to the Medical Executive Committee within five (5) days of the affected Members' receipt of notice concerning the identity of the ad hoc hearing committee, and state with particularity the reasons for such objection. In the event the Medical Executive Committee sustains the affected Members' objection, it shall designate another Member to serve as a replacement for the ad hoc hearing committee appointee that has been removed.

C. A simple majority of the ad hoc hearing committee shall constitute a quorum. Ad hoc hearing committee members who are not present at one or more sessions of the hearing may vote on all decisions made by the ad hoc hearing committee provided they are adequately apprised of the matters considered by the ad hoc hearing committee in their absence, through review of appropriate transcripts, minutes, exhibits or such other information as may be appropriate with respect to that session for which the member did not attend. No member may vote by proxy.

D. The ad hoc hearing committee may, without advance notice to the affected Member, conduct one or more organizational meetings for the purpose of planning its schedule and addressing other matters that do not affect the substantive rights of the affected Member.

*9.4.5 ***Time and Place for Hearing.*** The Chair of the ad hoc hearing committee shall schedule and arrange for the hearing, and shall give written notice to the practitioner of the date, time and place of the hearing and identify the Members comprising the ad hoc hearing committee. The hearing shall commence not less than thirty (30) or more than forty-five (45) days after the date of the notice; provided, however, that the time limit for commencement of the hearing may be altered by agreement of the affected Member and the Chair of the ad hoc hearing committee for good cause. The affected Member may request an extension of the hearing date up to an additional twenty-one (21) days upon a showing of good cause.

9.4.6 ***Pre-Hearing Conference.*** The ad hoc hearing committee may require the affected Member and counsel to participate in a pre-hearing conference, to be held not later than five (5) days prior to the hearing, for the purpose of resolving all procedural questions in advance of the hearing. The ad hoc hearing committee may specifically require that:

A. all documentary evidence to be submitted at the hearing be presented and any objections to the same be made known for resolution by the ad hoc hearing committee at this pre-hearing conference;

B. evidence unrelated to the reasons for the unfavorable recommendation or unrelated to the Member's qualifications for appointment or the relevant clinical privileges be excluded;

C. the names of all witnesses and a brief statement of their anticipated testimony be submitted if not previously provided;

D. the time granted to each witness for purposes of testifying and cross-examination be agreed upon, or established by the ad hoc hearing committee, in advance; and

E. witnesses and documentation not provided and agreed upon in advance of the hearing may be excluded from the hearing.

9.4.7 ***Request for Witnesses and Documents.***

A. If either party, by written notice, requests a list of witnesses, then each party, not later than ten (10) days after the request is made, shall furnish to the other a written list of the names and addresses of the witnesses that such party anticipates to be called. Each party shall exchange a list of witnesses no later than five (5) days before the hearing.

B. Either party, by written notice, may request that the other party provide a list of, or copies of, all documents (including, but not limited to, relevant patient medical records, incident reports, department or committee minutes, memoranda, correspondence, books, or articles) that will be proffered as evidence or relied upon by witnesses or others at the hearing. Any such request shall be made sufficiently in advance of the hearing date so that the documents can be produced and reviewed by the party submitting the request before the hearing.

9.4.8 ***Conduct of Ad hoc Hearing***

A. The personal presence of the affected Member for whom the hearing has been scheduled is required. A Member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his right to a hearing and the adverse recommendation or decision for which review was sought shall

become effective as provided in this Article IX.

B. The affected Member and the Executive Committee (or Board) shall have the following rights in the conduct of the ad hoc hearing:

- To representation by an attorney or by a Member of the active Medical Staff;
- To have a record made of the proceedings by a licensed court reporter, a copy of which may be obtained by the affected Member upon payment of any reasonable charges associated with the preparation thereof;
- To call, examine and cross-examine witnesses;
- To present evidence determined to be relevant by the ad hoc hearing committee, regardless of such evidence in a court of law; and
- To submit a written statement at the close of the hearing.

C. Either a hearing officer, if one is appointed, or the Chair of the ad hoc hearing committee, shall preside at the hearing, maintain decorum and ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence.

D. The affected Member and the representative(s) of the Medical Executive Committee or Board may be represented by legal counsel or a Member of the active Medical Staff. The ad hoc hearing committee may elect, in its sole discretion, to appoint a hearing officer to preside at the hearing and assist the ad hoc hearing committee in the conduct of the hearing and in ruling upon all questions regarding the admissibility of evidence. The hearing officer shall be an attorney licensed to practice in the State of Arkansas.

E. The hearing shall not be conducted in accordance with the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted if it is the sort of evidence upon which responsible persons customarily rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Evidence shall be admitted if its probative value is not outweighed by its unfairness. Evidence that is not relevant or which is repetitious may be excluded. The ad hoc hearing committee may admit hearsay evidence that is relevant and otherwise admissible under this Article, but may give less weight to that evidence than direct evidence. The ad hoc hearing committee may interrogate witnesses, and may, on its own initiative, request the presence of such occurrence or expert witnesses, as it deems appropriate. If the affected Member does not testify in his own behalf, he may be called and examined as if under cross-examination. It shall be the responsibility of the affected Member to procure the attendance of any witnesses

the affected Member desires to testify on his behalf.

F. The Executive Committee (or Board) shall appoint one of its members or some other Member to represent it at the hearing, to present the facts in support of its adverse recommendation or action and to examine witnesses. The Executive Committee (or Board) shall have the initial obligation to present evidence in support of the adverse recommendation or action, but the affected Member shall have the burden of proving by clear and convincing evidence that the adverse recommendation or action at issue is not supported by any factual basis or that the recommendation or action supported thereby is either arbitrary, unreasonable or capricious.

G. The Chair of the ad hoc hearing committee may, without formal notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The ad hoc hearing committee may thereupon at a time convenient to itself, conduct its deliberations in private.

H. Within twenty (20) days after the conclusion of the hearing, the ad hoc hearing committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Executive Committee or to the Board, whichever appointed it. The report may recommend confirmation, modification or rejection of the original adverse recommendation of the Executive Committee or decision of the Board. At the next regular or special meeting of the Executive Committee or Board, as the case may be, which occurs after such body's receipt of the ad hoc hearing committee's report, the Executive Committee or Board shall act upon this report and recommendation and either adopt, reject, or modify the same. The decision of the Executive Committee or Board shall be made in writing, include a statement of the basis for that decision, and shall be forwarded to the Board together with the initial request for corrective action, the investigative report of the Departmental ad hoc committee, the written statement of charges and notice of hearing rights required under Section 9.4.1, the transcribed record made before the ad hoc hearing committee, and the written report of the ad hoc hearing committee (collectively referred to hereinafter as "the Record"). A copy of the Executive Committee or Board decision shall be delivered to the affected Member, the Executive Committee or Board representative and the Administrator.

9.5. Appellate Review

9.5.1 ***Basis for Appellate Review.*** If, after considering the decision of the ad hoc hearing committee, (a) the Medical Executive Committee recommends that the Board take any action set forth under Section 9.4.1 of this Article IX, or (b) the Board recommends taking a final action set forth under Section 9.4.1 of this Article IX then, and only then,

shall the affected Member be entitled to an appeal to the Board under this Part 9.5.

9.5.2 ***Time for Requesting Appellate Review***. Within ten (10) days after receipt of notice by an affected Member of an adverse recommendation or decision made or adhered to after a hearing as provided in Part 9.4 of these Bylaws, the affected Member may, by written notice to the Board, delivered through the Chief of Staff by certified mail, return receipt requested, request appellate review by the Board. Appellate review shall be limited to the Record on which the adverse recommendation or decision is based unless the affected Member in such notice requests oral argument as part of the appellate review. The notice requesting appellate review shall set forth the grounds for appeal as set forth in Section 9.5.3 and be accompanied by the written statement required in Section 9.5.5(a). If appellate review is not requested within the ten (10) day period provided in this Section 9.5.2, the affected Member shall be deemed to have waived his right to such review and the same shall become effective upon final consideration by the Board as provided in Section 9.1.7(a).

9.5.3 ***Grounds for Appellate Review.*** The grounds for appellate review shall be limited to the following:

A. an allegation that there exists a substantial failure on the part of the ad hoc hearing committee, the Executive Committee or Board to comply with these Bylaws in the conduct of the hearings or in their decision, so as to deny the affected Member due process or a fair hearing; or

B. an allegation that the recommendation or decision of the ad hoc hearing committee, the Executive Committee or Board was arbitrary, capricious, or was clearly contrary to the weight of the evidence.

9.5.4 ***Notice of Time, Date, Place for Appellate Review Meeting.*** Within ten (10) days after receipt of such a notice of request for appellate review, the Board shall schedule a date for conducting such review, including a time and place for oral argument if such has been requested by the affected Member, and shall, through the Chief of Staff, send written notice advising the affected Member of the same.

9.5.5 ***Conduct of Appellate Review.***

A. The affected Member shall have access to the Record on which the adverse recommendation or decision is based. The affected Member shall submit a separate written statement together with the notice of request for appellate review, which statement sets forth the specific findings of fact, conclusions, and procedural matters with which he disagrees and the reasons for such disagreement. The written statement may cover any matter raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. The Executive Committee or Board, as the case may be, shall submit a written response within fifteen (15) days after the Board's receipt of the affected Member's notice of request for appellate review and written statement. A copy of

such response shall be provided to the affected Member at the time the response is served upon the Board.

B. The Board shall act as the appellate review body, or the Board may appoint the Joint Conference Committee to serve as the appellate review body where the adverse action being appealed from originated with the Board in the first instance. Knowledge of the matter shall not preclude any person from serving as a member of the appellate review body, so long as that person did not take part in a prior hearing on the same matter. The Board (or Joint Conference Committee) shall review the Record created in the proceeding, the written statements submitted pursuant to this Section 9.5.5, and the oral argument, if requested by the affected Member. If oral argument is requested, the affected Member shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him by any member of the Board or the Joint Conference Committee. An individual shall also represent the Medical Executive Committee or Board, as the case may be, and be permitted to speak in favor of the adverse recommendation or decision, and shall answer questions put to him by any member of the Board or the Joint Conference Committee. The affected Member, the Medical Executive Committee or the Board, as the case may be, together with the Board or Joint Conference Committee sitting as the appellate panel shall have the right to be represented by legal counsel during the appellate review. At the conclusion of the arguments, if any, the Board or Joint Conference Committee, as the case may be, shall promptly conduct deliberations in executive session.

C. New or additional matters not raised or presented during the hearing or in the ad hoc hearing committee report and not otherwise reflected in the Record shall be introduced at the appellate review stage only upon a showing of good cause, and the Board or Joint Conference Committee, as the case may be, in the exercise of its sole discretion shall determine whether such good cause exists and has been demonstrated.

D. The Chairman of the Board, or Chair of the Joint Conference Committee, may, from time to time, adjourn and continue the appellate review proceedings to another date or time if in the discretion of the Chairman such action is necessary or desirable to the conduct of a fair and thorough appellate review. Upon submission of the Record, the written statements of the parties, and the conclusion of oral argument, if any, the Board or Joint Conference Committee, as the case may be, may thereupon at a time convenient to itself, conduct its deliberations in private. Where the Joint Conference Committee sits as the appellate review body, the Joint Conference Committee shall forward its written recommendation to the Board for final action within five (5) days after the conclusion of the appellate review proceeding.

E. The Board may adopt, modify or reject the recommendation of the Medical Executive Committee (or Board), or, in its discretion, refer the matter back to the

Medical Executive Committee for further review and recommendation, to be made within ten (10) days. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve specific issues.

F. The Board shall render a final decision in writing within seven (7) days after the conclusion of appellate review, which shall contain a statement of the basis for its decision. Copies of the decision shall be delivered to the affected Member by certified mail, return receipt requested, and to the Medical Executive Committee. If the decision of the Board is in accordance with the Medical Executive Committee's recommendation in the matter, it shall be final and of immediate effect and shall not be subject to further hearings or review. In the event the decision of the Board is contrary to the most recent Medical Executive Committee recommendation, the Board shall refer the matter to the Joint Conference Committee. The Joint Conference Committee shall review the Record together with the written statements submitted on appeal and forward a recommendation to the Board within ten (10) days. The affected Member shall be notified by the Board in writing that the matter has been referred to the Joint Conference Committee for further review and that a final decision will not be made until the recommendation of the Joint Conference Committee has been received and considered by the Board. At its next regular or special meeting after receipt of the Joint Conference Committee's recommendation, the Board shall make its final decision with like effect and notice as described in this Section 9.5.5(e).

G. Appellate review shall not be deemed concluded until all of the procedural steps provided in this Article IX have been completed or waived.

9.6. Right To Only One Hearing and Appeal

A Member shall be entitled to only one hearing and one appeal in connection with any single matter that is properly the subject of a hearing and appeal pursuant to these Bylaws, regardless of whether the action is by the Executive Committee or the Board, or by both.

9.7. Reports to the National Practitioner Data Bank

The Hospital or its authorized representative shall report all adverse actions, as defined in the Health Care Quality Improvement Act of 1986, to the National Practitioner Data Bank only upon the adoption by the Board of such adverse action as being a final action of the Board, or as otherwise required by law. The Board's adoption of such adverse action as a final action shall occur only after the hearing process set forth in these Bylaws has been followed.

ARTICLE X

IMMUNITY FROM LIABILITY

10.1 Immunity from Liability

10.1.1 The following shall be express conditions to any Applicant for Medical Staff membership or clinical privileges at Washington Regional:

A. Any Applicant consents to have authorized members of the Credentials Committee, Service, Department, and Executive Committee consult with any and all members of the medical and dental staff of other hospitals with which the Applicant has been associated, concerning the Applicant's professional competence and qualifications, as well as other persons or entities that may have information bearing on the Applicant's professional competence or qualifications. The Applicant further consents to the inspection of any and all records made at such hospitals or other entities which would be material to an evaluation of the Applicant's professional competence or qualifications to perform the Clinical Privileges requested.

B. Any act, communication, report, or recommendation with respect to any such Applicant, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining reasonable patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

C. Such privilege shall extend to all Members of Washington Regional's Medical Staff, the Members of the Washington Regional Board, as well as its Administrator, officers, employees and other authorized representatives, and to third parties who supply information to any of the foregoing who are authorized to receive, release, or act upon same. For the purpose of this Article, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Board or of the Medical Staff.

D. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged. The immunity protections afforded in these Bylaws are in addition to those prescribed by applicable state and federal law.

E. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures, performed or made in connection with Washington Regional's or any other health care institution's activities

related, but not limited to:

1. applications for Medical Staff appointment and/or Clinical Privileges;

2. periodic reappraisals for reappointment and/or Clinical Privileges;

3. corrective or disciplinary action, including any statutory reporting requirements;

4. hearings and appellate reviews;

5. quality assessment, performance improvement, and peer review activities;

6. utilization review and improvement activities;

7. claims reviews;

8. risk management and liability prevention activities; and

9. other Washington Regional, Service, Department or Medical Staff committee activities related to monitoring and maintaining quality patient care and efficient patient care and appropriate professional conduct.

F. Acts, communications, reports, recommendations, and disclosures referred to in this Article X may relate to an Applicant's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

G. Each Applicant shall, upon request of Washington Regional, execute written releases in accordance with the tenor and import of this Article X in favor of the individuals and organizations specified in this Article X.

H. The consents, authorizations, releases, rights, privileges, and immunities referred to in this Article X for the protection of Members, other appropriate Washington Regional officials and personnel and third parties, in connection with applications for initial appointment to the Medical Staff shall also be fully applicable to the activities and procedures covered by this Article X.

10.2 Confidentiality of Information

10.2.1 To the Fullest extent permitted by law, including Ark. Code Ann. §16-46-105, the following shall be kept confidential:

A. Information submitted, collected, or prepared by any representative of Washington Regional or any other healthcare facility or organization or medical staff for the purpose of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of medical and hospital care rendered at Washington Regional; and

B. Evaluations of current competence and qualifications for Medical Staff appointment and/or Clinical Privileges;

10.2.2 The information described in Section 10.2.1 shall not be disseminated to anyone other than representatives of Washington Regional or other healthcare facilities who are engaged in authorized peer review and/or quality assurance activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties to representatives of Washington Regional for peer review or quality assurance activities. Because effective peer review and proper consideration of the qualifications of Physicians, Allied Health Professionals and Applicants to competently perform specific medical procedures must be based on free and candid discussions, each Member expressly acknowledges that any violation or breach of the confidentiality provisions outlined in this Section 10.2 is outside appropriate standards of conduct for Members of the Washington Regional Medical Staff, may violate provisions of state and federal law and regulations, and, therefore, shall be grounds for immediate termination of such Member's Medical Staff appointment and/or Clinical Privileges.

ARTICLE XI

RULES AND REGULATIONS AND POLICY ON AMENDING BYLAWS, RULES AND REGULATIONS

11.1 Rules, Regulations and Policies

The Medical Executive Committee shall formulate, review at least biennially, and recommend to the Board such rules, regulations and policies as may be necessary to implement more specifically the general principles stated within these Bylaws. Rules, regulations and policies shall relate to the proper conduct of Medical Staff activities as well as set standards of practice required of each Member of the Medical Staff. Rules, regulations and policies shall have the same force and effect as the Bylaws, though in the event of any conflict between provisions of the Bylaws and the rules, regulations and policies of the Medical Staff, provisions set forth in the Bylaws shall control.

11.1.1 Medical Staff rules, regulations and policies may be adopted or amended by a majority vote of the members of the Medical Executive Committee. Notice of all proposed rules, regulations and policies, as well as amendments thereto, shall be delivered to each Member of the Medical Staff at least ten (10) days prior to the scheduled meeting of the Medical Executive Committee at which the proposed rule, regulation or policy, or

amendment thereto, will be voted upon. Any Member of the Medical Staff may submit written comments regarding a proposed rule, regulation or policy, or amendment to the rules, regulations and policies, by delivering the same to the Chief of the Medical Staff prior to the scheduled vote.

11.1.2 Medical Staff rules, regulations and policies, as well as amendments thereto, may also be proposed to the Board by the Members of the Active Medical Staff. Proposed rules, regulations or policies, as well as amendments thereto, may be brought before the Active Medical Staff by petition signed by one-fourth (25%) of the Members of the Active Medical Staff. Any such proposed rule, regulation or policy, or amendment thereto, will be reviewed by the Medical Executive Committee, which may comment on the proposal before it is forwarded to the Members of the Active Medical Staff. Any proposed rule, regulation or policy, or amendment thereto, that has satisfied the requirements set forth in this Section 11.1.2 shall be presented to the Active Medical Staff for a vote at a regular or special meeting of the Medical Staff or by means of a printed or secure electronic ballot in a manner established by the Medical Executive Committee. If a quorum is present for the purpose of enacting a proposed rule, regulation or policy, or amendment thereto, approval shall require an affirmative vote of fifty-one percent (51%) of the Active Medical Staff voting in person at the meeting or by written or electronic ballot.

11.2 Medical Staff Bylaws

The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any medical staff bylaws as may be necessary to the governance and orderly operation of the Medical Staff at WRMC.

11.2.1 Proposal of Amendments. Amendments to these Bylaws may be proposed for consideration of the Active Medical Staff as follows:

A. The Medical Executive Committee may propose an amendment to the Bylaws, provided that each of the following steps has occurred prior to any vote concerning the proposed amendment by the Active Medical Staff:

1. Copies of the proposed amendment must be delivered to the Bylaws Committee, which shall independently review the proposed amendment and provide a written report of its recommendations to the Medical Executive Committee.

2. Copies of the proposed amendment must be delivered to all Members of the Medical Staff at least twenty-one (21) days prior to being voted upon by the Medical Executive Committee. Any Member of the Medical Staff who desires to submit written comments regarding the proposed amendment must do so at least seven (7) days prior to the proposed amendment being voted upon by the Medical Executive Committee.

B. Members of the Medical Staff may propose amendments to these Bylaws, provided that each of the following steps has occurred prior to any vote concerning the

proposed amendment by the Active Medical Staff:

1. The proposed amendment must be endorsed in writing by at least twenty-five percent (25%) of the Active Medical Staff.

2. Copies of the proposed amendment together with appropriate documentation evidencing endorsement by the requisite percentage of Active Medical Staff Members must be delivered to the Bylaws Committee, which shall review the proposed amendment and provide a written report of its recommendation to the Medical Executive Committee.

3. Copies of the proposed amendment together with appropriate documentation evidencing endorsement by the requisite percentage of Active Medical Staff Members must be delivered to the Medical Executive Committee. The Medical Executive Committee shall review the proposed amendment, together with the recommendation of the Bylaws Committee, and shall prepare a written report indicating either a favorable or unfavorable recommendation regarding the proposed amendment. A copy of the proposed amendment together with the recommendation of the Medical Executive Committee must be delivered to all Members of the Active Medical Staff at least twenty-one (21) days prior to being voted upon by the Members of the Active Medical Staff.

11.2.2 Voting on Amendments. Any proposed amendment that has satisfied the requirements set forth in Section 11.2.1 shall be presented to the Active Medical Staff for a vote at a regular or special meeting of the Medical Staff or by means of a printed or secure electronic ballot in a manner established by the Medical Executive Committee. The Medical Executive Committee shall simultaneously deliver to the Members of the Active Medical Staff a copy of any written report prepared pursuant to Section 11.2.1.A.2, Section 11.2.1.B.2, and/or Section 11.2.1.B.3. If a quorum is present for the purpose of enacting a proposed change to the Bylaws, the change shall require an affirmative vote of fifty-one percent (51%) of the Active Medical Staff voting in person at the meeting or by written or electronic ballot.

11.3 Delivery of Proposed Amendments, Reports, and Ballots

For purposes of this Article XI, the delivery of any proposed amendment, report, or ballot may be accomplished by regular mail, electronic mail, the Washington Regional Medical Center intranet, facsimile, or other reasonable means.

11.4 Technical or Legal Changes to Bylaws, Rules, Regulations and Policies

The provisions of Section 11.2.1 notwithstanding, the Medical Executive Committee may provisionally adopt such amendments to the Bylaws, Rules and Regulations, and policies of the Medical Staff that are, in the good faith judgment of the Medical Executive Committee, technical or legal modifications or clarifications, consist of reorganization or renumbering of material, or as are necessitated to correct errors of grammar or expression. All such amendments must be ratified by (i) the Medical Staff within one year of adoption by the Medical Executive

Committee through an affirmative vote of the Active Medical Staff which satisfies the quorum and threshold requirements set forth in Section 11.2.2, and (ii) the Board.

11.5 Governing Board Approval

All proposed Medical Staff bylaws, rules, regulations, or policies, including any amendments thereto, shall become effective only after approval by the Board of Directors of Washington Regional Medical Center. In the event of a conflict between the Medical Staff Bylaws and the Washington Regional Medical Center Bylaws, the Washington Regional Medical Center Bylaws shall prevail.

11.6 Conflict Management Committee

11.6.1 In the event of a conflict between Members of the Active Medical Staff and the Medical Executive Committee regarding the adoption of any Bylaw, Rule and Regulation, or policy, or any amendment thereto, or with regard to any other matter of significance to the Medical Staff, upon delivery to the Chief of Staff of a petition signed by twenty-five percent (25%) of the Members of the Active Medical Staff the matter shall be submitted to the Conflict Management Committee, as defined below. The meeting of the Conflict Management Committee will be scheduled by the Chief of Staff within thirty (30) days of his or her receipt of the petition requesting a meeting of a Conflict Management Committee.

11.6.2 A Conflict Management Committee shall be formed consisting of up to five (5) representatives of the Active Medical Staff designated by the Active Members submitting the petition and an equal number of representatives of the Medical Executive Committee appointed by the Chief of Staff. The Administrator and Chief Medical Officer, or their respective designee(s), shall be ex-officio, non-voting members of the Conflict Management Committee.

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

11.6.4 Any recommendation which is approved by a majority of the Active Member representatives and a majority of the Medical Executive Committee representatives shall be submitted to the Board of Directors for consideration and subject to final approval by the Board. If agreement cannot be reached by a majority of the Active Member representatives and a majority of the Medical Executive Committee representatives, the members of the Conflict Management Committee shall individually or collectively report to the Board of Directors regarding the unresolved dispute for consideration by the Board of Directors in making its final decision regarding the dispute. The Conflict Management Committee will submit its recommendation to the Board within thirty (30) days of its meeting.

11.7 Joint Conference Committee

If the Board of Directors of Washington Regional Medical Center determines not to accept a recommendation regarding a Bylaw, rule, regulation or policy submitted for the Board's consideration after approval by the Medical Staff in accordance with the provision of this Article XI, the Medical Executive Committee shall be entitled to request a meeting of the Joint Conference Committee. The Joint Conference Committee shall serve as a forum for further discussion of the rationale of the Board for its action, and afford an opportunity for the Officers of the Medical Staff to further articulate to the Board the rationale of the Medical Staff for its recommendation. The meeting of the Joint Conference Committee will be scheduled by the Chief Executive Officer within two weeks after receipt of a request for a meeting of the Joint Conference Committee submitted by the Chief of Staff to the Chairman of the Board. The Joint Conference Committee will submit its recommendation to the Board within thirty (30) days of its meeting.

ARTICLE XII

COMMITTEES

12.1 General

12.1.1 Medical Staff committees shall include, but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of the Departments and Services, meetings of committees established under this Article XII, and meetings of special or ad hoc committees created by the Executive Committee or Departments pursuant to these Bylaws. The committees described in Section 12.9 of this Article XII shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Executive Committee, the Chief of Staff, or the Departmental Control Committees to perform specified tasks. All committees report and are accountable to the Executive Committee. All committees, whether standing or special, shall have as their primary purpose that of improving patient safety and quality of patient care.

12.1.2 For purposes of fulfilling the obligation delegated to the Medical Staff by the Board to ensure the provision of appropriate, quality care to patients of Washington Regional, and to ensure that Members engaged in fulfilling the Medical Staff's responsibilities in this regard are afforded the full protection of state and federal laws and regulations applicable to the conduct of quality assurance and peer review activities, every Medical Staff committee operating pursuant to these bylaws, including but not limited to the Medical Executive Committee, Credentials Committee, Physician Health Committee, Peer Review Committee, Medical Ethics Committee, Trauma Committee, any ad hoc hearing committee, or other standing or special committee of the Medical Staff, shall be a "peer review committee" within the meaning of Ark. Code Ann. §§20-9-501 *et seq*., and the records of all such committees shall be entitled to the maintenance of confidentiality and protections afforded by Ark. Code Ann. §16-46-105.

12.1.3 Except as provided otherwise in these Bylaws, the members of all standing and special committees shall be appointed by the Chief of Staff, subject to the approval of the Executive Committee.

12.1.4 The membership of the Executive Committee, Credentials Committee, Bylaws Committee, and Nominating Committee shall be determined in accordance with the provisions of Section 12.9 of these Bylaws.

12.1.5 As a condition to serving on a committee or attending a Departmental meeting, each Member agrees not to divulge any of the peer review proceedings or the contents of documents produced at any committee meeting. Failure to abide by the confidential nature of the committee or meeting shall subject the Member to immediate corrective action, including removal from the committee and termination from the Medical Staff.

12.1.6 Special committees and ad hoc committees are those appointed for a limited period to perform a specific task. The appointment of a special committee or ad hoc committee shall be in writing, shall identify the officer or committee to whom it reports and the

duties of the committee. Special and ad hoc committees shall not have power of action unless the motion which created the committee specifically grants such authority.

12.1.7 Standing committees are those committees identified in Section 12.8 of this Article XII which have an ongoing purpose.

12.1.8 Unless otherwise specified in these Bylaws, members of standing committees shall be appointed for a term of two (2) years. Committee members shall serve until the end of this two (2) year period or until the member's successor is appointed, unless the member earlier resigns or is removed from the committee.

12.2 Removal

12.2.1 If a member of a committee ceases to be a Member in good standing of the Medical Staff, suffers a loss or limitation of Clinical Privileges, or if any other good cause shall exist, that member may be removed from the committee by the Chief of Staff, subject to approval by the Executive Committee.

12.3 Vacancies

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

12.4 Addition, Deletion, or Modification of Standing Committees of the Medical Staff

12.4.1 The Executive Committee may recommend to the Medical Staff and Board the addition, elimination, or modification of the duties or existence of any standing committee of the Medical Staff, with the exception of the Executive Committee and Credentials Committee.

12.5 Executive Session

12.5.1 The chair of any standing or special committee of the Medical Staff may call an executive session meeting. The Administrator of Washington Regional or his designee, if acceptable to the chairman, shall be entitled to attend any executive session, as are other individuals whose presence is requested by the chairman. A Member shall attend all committee meetings at which the chairman requests his presence.

12.6 Quorum

12.6.1 Executive Committee: The presence of Fifty (50%) percent of the total membership of the Executive Committee eligible to vote shall constitute a quorum for the transaction of any business, and the action of a majority of the quorum shall constitute action of the Executive Committee.

12.6.2 General Medical Staff Meetings: The presence of twenty-five percent (25%) of the total Members of the Active category of the Medical Staff shall constitute a quorum for the transaction of any business, and the action of a majority of the quorum shall constitute the action of the General Medical Staff.

12.6.3 Other Medical Staff committee meeting(s): The presence of the greater of two (2) members or twenty-five (25%) percent of the total membership of the committee eligible to vote shall constitute a quorum for the transaction of any business, and the action of a majority of the quorum shall constitute action of the committee.

12.7 Minutes

12.7.1 All committees will maintain permanent written minutes of proceedings and actions. Minutes shall be forwarded to the Departmental Control Committees and to the Medical Executive Committee for review.

12.8 Voting

12.8.1 Members of any committee shall be entitled to vote in person and not by proxy. No committee member shall vote on any matter in which he has a conflict of interest.

12.9 Standing Committees of the Medical Staff

The standing committees of the Medical Staff are as follows:

12.9.1 Executive Committee

12.9.2 Medicine and Surgery Department Control Committees

12.9.3 Nominating Committee

12.9.4 Department Nominating Committee

12.9.5 Bylaws Committee

12.9.6 Credentials Committee

12.9.7 Continuing Medical Education and Electronic Health Reference Library Committee

12.9.8 Critical Care Committee

12.9.9 Infection Prevention and Control Committee

12.9.10 Institutional Review Board

12.9.11 Medical Ethics Committee

12.9.12 Physician Health Committee

12.9.13 Pharmacy and Therapeutics Committee

12.9.14 Radiation Safety Committee

12.9.15 Joint Conference Committee

12.9.16 Trauma Committee

12.9.17 Physician Peer Review Committee

12.9.18 Medical Records Committee

12.9.19 Transfusion Committee

The composition of each committee is set forth in the following chart and corresponds to the Section number assigned each committee above.

12.9.1 Executive Committee

A. The Executive Committee shall:

1. represent and act on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

2. manage the affairs and organization of the Medical Staff, and enforce Bylaws, Rules and Regulations;

3. coordinate and implement the professional and organizational activities and policies of the Medical Staff;

4. receive and act upon reports and recommendations from Medical Staff committees, Departments, and Services;

5. take all reasonable steps to ensure professional and ethical conduct and competent clinical performance on the part of all Members, including the initiation of and/or participation in Medical Staff corrective action or review measures when warranted;

6. fulfill the Medical Staff's responsibility to account to the Board for the overall quality, appropriateness, efficiency, and effectiveness of medical care rendered to the patients in Washington Regional by Members of the Medical Staff and Allied Health Staff;

7. provide liaison among the Medical Staff, the Administrator, and the Board;

8. oversee the quality improvement activities of the Medical Staff, as well as the mechanism used to conduct, evaluate, and revise such activities;

9. review the qualifications, credentials, performance and professional competence, and character of all Applicants and Medical Staff Members and make recommendations to the Board regarding Medical Staff appointments and reappointments, assignments to Departments, delineation of Clinical Privileges, and corrective action;

10. review and recommend to the Board for approval or disapproval, all Bylaws, Rules and Regulations proposed by the Executive Committee, any Department or Service of the Medical Staff;

11. keep the Medical Staff advised as to accreditation and regulatory requirements affecting Washington Regional;

12. approve off-site and contracted sources for needed patient care services;

13. participate in identifying community health needs and setting Washington Regional goals and establishing plans and programs to meet those goals;

14. represent and act on behalf of the Medical Staff with regard to all matters not expressly reserved to the voting Members of the Medical Staff, without requirement of subsequent approval by the Medical Staff, subject only to such limitations as are expressly set forth in these Bylaws;

15. develop and recommend to the Board for approval or disapproval, all application forms for membership to the Medical Staff and Allied Health Staff;

16. perform any other duties assigned by these Bylaws.

12.9.2 Medicine and Surgery Department Control Committees

A. The Control Committees of the Department of Medicine and the Department of Surgery shall:

1. coordinate and implement the professional and organizational activities and policies, rules and regulations of the Department;

2. receive and act upon reports and recommendations from the Services within the Department;

3. make recommendations on behalf of the Department to the Executive Committee;
4. review the qualifications, credentials, performance and professional competence, and character of all Applicants and Medical Staff Members who seek Medical Staff appointment and Clinical Privileges that fall under the jurisdiction of the Department and make recommendations to the Credentials Committee and Executive Committee regarding Medical Staff appointments and reappointments, assignments to the Department and Services, delineation of Clinical Privileges, and corrective action;
5. implement a planned and systematic process for monitoring and evaluating the quality and appropriateness of care and treatment of patients served by the Department and the performance of all Members with Clinical Privileges in the Department;
6. resolve problems of an intra-Departmental nature; and
7. take all reasonable steps to ensure that all Members of the Department continuously maintain the professional qualifications and requirements mandated under these Bylaws and to initiate any prescribed corrective measures when indicated

12.9.3 Nominating Committee

A. The Nominating Committee shall:

1. Select a slate of nominees for the office of Vice Chief of Staff, as well as the membership of the Nominating Committee and the Bylaws Committee.

2. The slate of nominees shall be communicated by the Nominating Committee to the Medical Staff in written or electronic format at least thirty (30) days prior to the general meeting of the Medical Staff at which the nominees shall be voted upon.

12.9.4 Department Nominating Committees

A. The Department nominating committee shall have responsibility for:

1. preparing a slate of nominees for:

   i. The office of Department Vice Chair;
   ii. The at-large positions on the Executive Committee to be held by two (2) qualified Members of the Department; and
   iii. The positions on the Credentials Committee to be held by three (3) qualified Members of the Department.

2. Each slate of nominees shall be submitted to the Department chair no later

than sixty (60) days prior to the biannual general Medical Staff meeting at which the elections shall take place. The Department chair shall ensure that written notification of the nominees and position for which the nominees have been nominated is submitted to the Members of the Department, together with notice as to the date, time and location of the general Medical Staff Meeting, no later than thirty (30) days prior to the date of the general Medical Staff Meeting.

12.9.5 Bylaws Committee

A. The Bylaws Committee shall:

1. interpret and provide guidance regarding the Bylaws, Rules and Regulations of the Medical Staff;

2. review, at least annually, and make recommendations to the Executive Committee, if appropriate, relating to amendments to the Bylaws, Rules and Regulations as necessary to reflect current Medical Staff practice; and

3. receiving and evaluating for recommendation to the Executive Committee proposed amendments to the Bylaws as specified in Section 11.2 of these Bylaws.

12.9.6 Credentials Committee

A. The Credentials Committee shall:

1. review and evaluate the qualifications of each Physician and Allied Health Professional applying for initial appointment and reappointment to the Medical Staff, and/or Clinical Privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate Services;

2. investigate, review and report on matters referred to it by the Chief of Staff or the Executive Committee regarding the qualifications, conduct, professional character or competence of any Applicant or Medical Staff Member, or Allied Health Staff member;

3. submit to the Department Control Committee required reports and information as to the qualifications of each Physician and Allied Health Professional applying for Medical Staff or Allied Health Staff appointment, reappointment and/or Clinical Privileges, including recommendations with respect to appointment, reappointment, membership category, Department affiliation, Clinical Privileges, and special conditions, if any;

4. review the Medical Staff credentialing policies at least annually and present recommendations for any changes to the Executive Committee;

5. review, recommend, and establish credentialing requirements for all requested privileges; and

6. conduct such other activities as may be reserved to the Credentials Committee in these Bylaws or as may be requested by the Executive Committee or Board.

12.9.7 Continuing Medical Education (CME) and Electronic Health Reference Library Committee

A. The continuing medical education committee shall:

1. abide by the mission of the CME committee;

2. abide by the policies of Washington Regional, in its role as a medical education sponsor, as set forth by the Accreditation Council for Continuing Medical Education (ACCME);

3. identify, review, assess and determine continuing medical education needs of the Medical Staff and its Members. The sources of educational need may be derived from any recognized source, including:

   a. Continuing review of changes in quality of care as revealed by medical audit, regulatory changes, or other patient care activities.
   b. Ongoing review of recurring diagnoses made by Members. c. Publications, statements or guidance issued by recognized medical authorities or medical societies.
   d. Requests from Members, the Departments, Services or other Medical Staff Committees.
   e. Initiatives promoted by the Centers for Medicare and Medicaid Services, The Joint Commission, the Agency for Healthcare Research and Quality, or other recognized accreditation or regulatory agencies.

4. assist in planning and implementing various educational programs and conferences for general or specific groups of the Medical Staff;

5. identify objectives for each program which will provide a mechanism for participants to evaluate the benefit of those programs; and

6. review and assess the benefits and outcomes of the programs sponsored by Washington Regional through appropriate mechanisms, such as program evaluations, surveys, and direct contact with other Members.

7. review and make recommendations regarding access to electronic health reference material.

8. assess immediate and long-term needs for electronic health reference library material.

9. recommend acquisitions and renewals of subscriptions for electronic health reference library materials to the Medical Executive Committee.

12.9.8 Critical Care Committee

A. The Critical Care Committee shall:

1. serve as a forum for discussion of clinical and operational issues in the critical care units;

2. evaluate quality of patient care in the critical care units, to see that safety standards are maintained, and to see that training and education of nursing staff and practitioners is maintained on a continuing basis;

3. seek ways and means, through quality improvement initiatives, for improving the professional standards and functions of these services for better patient care and proficiency in the execution of the detailed responsibilities; and

4. be responsible for formulating and assuming compliance with the established policies and procedures of the critical care units and for the maintenance of the highest professional conduct of the Medical Staff using these facilities.

12.9.9 Infection Prevention and Control Committee

A. The Infection Prevention and Control Committee shall:

1. regularly survey Washington Regional for risk of potential infection;

2. review and analyze actual infections;

3. promote a preventive and corrective program designed to minimize infection hazards;

4. institute any appropriate control measure or study when there is felt to be a risk to patients or personnel in Washington Regional; and

5. supervise infection control in all phases of Washington Regional's activities.

12.9.10 Institutional Review Board

A. The Institutional Review Board shall:

1. assure, both in advance and by periodic review, that appropriate steps are taken to protect the rights and welfare of humans participating as subjects in research;

2. serve as a forum for discussion of clinical risks to subjects so that such risks are minimized, using good clinical practice and sound research design and do not unnecessarily expose subjects to risk;

3. assure that risks to subjects are reasonable in relation to anticipated benefits and the knowledge that may be expected to result;

4. assure that selection of subjects is equitable;

5. assure that informed consent will be sought by the Member, who is the principal investigator, from each prospective subject or the subject's legally authorized representative and will be documented in accordance with the IRB Bylaws;

6. assure that the research plan makes adequate provision for monitoring of data collected to ensure the safety of subjects;

7. assure that there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data;

8. assure that appropriate additional safeguards have been included in the study to protect the rights and welfare of subjects who are members of a vulnerable group; and

9. develop policies and procedures, to be approved by the Executive Committee and Board, to ensure activities of the IRB comply with these Bylaws and applicable state and federal laws and regulations.

12.9.11 Medical Ethics Committee

A. The Medical Ethics Committee shall:

1. provide a forum for individuals within the institution to express concerns and seek guidance concerning ethical issues that arise pertaining to direct patient care;

2. define educational programs in ethics of health care;

3. assist Washington Regional in the review of policies and guidelines

regarding ethics which arise in the care of patients, and recommend development of new policies and guidelines as necessary;

4. provide consultation and advice to healthcare providers, patients, and family members when there is uncertainty or disagreement concerning medical ethical issues; and

5. analyze the overall experience of patients, family members, and Washington Regional staff, and make recommendations as to how to address their needs in the area of medical ethical decision making.

12.9.12 Physician Health Committee

A. The Medical Staff Physician Health Committee shall:

1. be the identified point within the hospital where information and concern about the health of an individual physician can be delivered for consideration;

2. receive and evaluate concerns about physician health or functioning while assuring maximum confidentiality; except when referrals are made as outlined in the Bylaws that may require possible corrective action;

3. seek collaboration and additional information;

4. provide advice, recommendations, and assistance, including educational and therapeutic referral to the physician in question and the person or group who contacted the committee (the referring source);

5. encourage a physician impaired by virtue of physical or psychiatric disease, problems in living, or problems of alcoholism or drug abuse to voluntarily accept referral for the treatment or assistance with an identified problem;

6. education to its own members and the Members of the Medical Staff about physical health, well-being and impairment; about appropriate responses to different levels and kinds of distress and impairment; and about appropriate resources for prevention, treatment, and rehabilitation.

12.9.13 Pharmacy and Therapeutics Committee

A. The Pharmacy and Therapeutics Committee shall:

1. assist in the development, implementation and monitoring of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to medications in Washington Regional;

2. advising the Medical Staff and the pharmacy on matters pertaining to the choice of available pharmaceuticals;

3. making recommendations concerning drugs to be stocked on nursing units;

4. assisting the pharmacy in the development and periodic review of a formulary or drug list for use in Washington Regional;

5. evaluating clinical data concerning new pharmaceuticals or preparations requested for use in Washington Regional;

6. in consultation with the Institutional Review Board, establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs; and

7. reviewing untoward and/or adverse medication reactions and interactions.

12.9.14 Radiation Safety Committee

A. The Radiation Safety Committee shall:

1. oversee the use of radioactive materials;

2. monitor the institutional program to maintain occupational dosed as low as reasonably achievable;

3. review and approve the credentials of all qualified Members requesting to be authorized users before sending a license application or request for amendment or renewal;

4. review and approve each proposed method of use of radioactive material based on safety considerations;

5. review and approve the credentials of the radiation safety officer and radiation physicist;

6. review occupational radiation exposure records of all personnel working with radioactive material and all incidents involving radioactive material at least every six (6) months, with the assistance of the radiation safety officer, to determine cause and review subsequent actions taken;

7. review the radioactive materials program at least every twelve (12) months with the assistance of the radiation safety officer; and

8. establish levels for occupational dosage that, when exceeded, will result in investigations and considerations of action by the radiation safety officer.

12.9.15 Joint Conference Committee. The Joint Conference Committee shall meet at the call of the Chief of Staff, the President and Chief Executive Officer, or the Chair of the Board of Directors. The Joint Conference Committee shall transmit written reports of its activities to the Medical Executive Committee and Board of Directors after each meeting. The Joint Conference Committee shall serve as an informal medical- administrative liaison between the Board of Directors, Administration and the Medical Staff with the object of enhancing the mutual understanding of the problems and activities of the Board of Directors, Administration and Medical Staff. The principal function of the Joint Conference Committee shall be to serve as a forum for the informal discussion and resolution of conflicts between or among the Medical Staff, Administration, and/or the Board of Directors as they arise and to exercise such other responsibilities as are assigned to the Joint Conference Committee as are set forth in these Bylaws. The Joint Conference Committee shall be responsible to communicate to the Board of Directors in order to permit the Board to resolve any differences between or among the Medical Staff, Administration, and /or the Board of Directors that cannot be resolved by the Joint Conference Committee.

12.9.16 Trauma Committee. Provided the Board of Directors approves the participation of Washington Regional Medical Center in the Arkansas Trauma Care System, the Trauma Committee shall:

A. conduct regular monthly meetings for the purpose of reviewing the provision of trauma services within Washington Regional, conducting quality improvement activities specific to trauma services within Washington Regional, and performing peer review of Members of the Trauma Service in coordination with other Medical Staff peer review committees;

B. serve as a forum for discussion of clinical and operational issues concerning the Trauma Service;

C. facilitate training and education of Medical Staff, Allied Health Staff, and nursing staff on a continuing basis regarding trauma services and the activities of the Arkansas Trauma Care System;

D. develop, implement and review and recommend to the Medical Executive Committee Medical Staff policies, procedures and protocols deemed necessary or advisable to the efficient conduct of trauma services within Washington Regional; and

E. review the qualifications, credentials, performance and professional competence of Members of the Trauma Service.

12.9.17 Physician Peer Review Committee. The Physician Peer Review Committee ("PPRC") serves to provide a forum for the Medical Staff to continually assess the quality and appropriateness of patient care services and processes. The goal of the PPRC is to oversee the conduct of a Medical Staff peer review process that continuously improves treatment services and processes within Washington Regional. The PPRC shall:

A. review the quality and appropriateness of treatment provided by Members of the Medical Staff;

B. identify opportunities for improvement in quality of care and clinical performance in both the inpatient and outpatient setting;

C. review (or delegate such review to other appropriate committees, Departments or Services) patient complaints, incident reports, or other matters concerning the quality of care and clinical performance of Members, and ensure that appropriate action is taken to address identified problems when warranted.

12.9.18 Medical Records Committee. The Medical Records Committee monitors the quality of medical records and works in collaboration with the Health Information Services Department to develop standards, policies and procedures that assure the adequacy and timely preparation of complete and organized medical records. The Medical Records Committee shall:

A. develop and implement systems to assure that medical records within Washington Regional meet such standards of completeness, accuracy, confidentiality, and legibility as are required to meet accreditation and regulatory standards;

B. develop, monitor compliance with, and enforce rules and regulations related to the timely and accurate completion of medical records such that a complete record is available for continuity of patient care and reimbursement purposes;

C. review data and trends related to the individual practitioner's completion of medical records and take action as appropriate;

D. review and approve all new medical record forms, including electronic health record power plans, forms or procedures;

E. implement a medical records review system to assure that medical records accurately reflect and document medical events occurring during hospitalization; and

F. authorize the permanent filing of a medical record when a practitioner, for whatever reason, is unable to complete documentation.

12.9.19 Transfusion Committee. The Transfusion Committee works to ensure safe and efficient utilization of blood products within Washington Regional. The Transfusion Committee develops, implements and oversees processes and

procedures to ensure that blood is ordered appropriately, safely administered and that wastage of blood products is minimized. In furtherance of the foregoing, the Committee shall:

1. Review reports of adverse reactions, incidents, and complaints;
2. Recommend process change to improve safety and efficiency;
3. Assist in identification and development of education tools for healthcare providers;
4. Review clinical metrics relating to blood product safety and administration efficiency, including monitoring trends and developing action plans with regard to:
    - Overall utilization trends
    - Wastage (overall and by provider)
        - Crossmatch to transfusion ratio
        - Transfusion to discarded ratio
    - MTP utilization
        - Indications
        - Wastage
        - Utilization and adherence to analytic results to guide therapy
    - Surgical blood utilization
        - Indications
        - Prediction tools for utilization to manage inventory
5. Review and advise Washington Regional staff on applicable clinical policies and procedures, including those in the areas of:
    - Informed Consent
    - Indications for blood usage
    - Patient identification, specimen collection, and transfusion technique
    - MTP protocol
    - Management of provider poor performance
    - New product review
    - Blood shortage management

Committee	Composition
12.9.1 Medical Executive	The Medical Executive Committee shall consist of the Chief of Staff, the Vice Chief of Staff, the Immediate Past Chief of Staff, the chair of the Department of Medicine, the chair of the Department of Surgery, and two (2) at-large Members appointed from each of the Departments. The at-large members shall be elected at the next special or regular meeting of the Department held immediately following the annual meeting of the Medical Staff held in odd-numbered calendar years. The Chief of Staff shall be the chair of the Medical Executive Committee. All members of the Medical Executive Committee shall be Members of the active Medical Staff. The Administrator, Chief Medical Officer, and Chief Nursing Officer shall be non-voting, ex-officio members. The Medical Executive Committee shall meet not less than monthly.
12.9.2 Medicine & Surgery Control	The Department Control Committee for each Department shall consist of the Department chair, the vice chair and the chair of each Service comprising the Department.
12.9.3 Nominating Committee	The Nominating Committee shall consist of not fewer than five (5) members of the Active Medical Staff, of which no member may succeed himself. The members of the Nominating Committee are elected at the annual general Medical Staff meeting in odd numbered years. The Committee membership shall elect their own chairman.
12.9.4 Departmental Nominating	The committee shall consist of three (3) members from each department appointed by the Department chairman in election years at least ninety (90) days prior to the general Medical Staff meeting at which the election of Department leadership shall take place. They are to elect their own chairman.
12.9.5 Bylaws Committee	The Bylaws Committee shall consist of not less than three (3) Members of the Active Medical Staff. The members are elected at the annual general Medical Staff meeting in odd numbered years. They are to elect their own chairman.
12.9.6 Credentials	The Credentials Committee shall consist of six (6) Members of the Active Medical Staff– three (3) from each Department who shall be elected at the next special or regular meeting of the Department held immediately following the annual meeting of the Medical Staff held in odd numbered calendar years. No Service may have more than one representative on the Credentials Committee. The committee shall elect its own chairman.
12.9.7 Continuing Medical Education and Electronic Health Reference Library	The Continuing Medical Education and Electronic Health Reference Library Committee shall consist of four (4) Members of the Active Staff, the CME coordinator, and the Chief Medical Officer.
12.9.8 Critical Care	The Critical Care Committee shall consist of no fewer than five (5) Members of the Active Staff trained in critical care including the medical directors of CCU and ICU; other members may be appointed as needed. The committee shall elects its own chairman.
12.9.9 Infection Prevention	The Infection Prevention and Control Committee shall be composed of three (3) Members of the Active Staff, representing the Department of Surgery, the Department of Medicine and the Pathology Service. The chairman shall be appointed by the Chief of Staff. Other voting

and Control	members of the committee shall be representatives from the following departments appointed by the Administrator: Administration, microbiology, maintenance, the operating suite, housekeeping, central supply, the epidemiologist and employee health nurse. Other members may be appointed as deemed necessary by the committee.
129.10 Institutional Review Board	The committee shall consist of no fewer than eight (8) voting members. The composition of this minimum number of members shall be three (3) Members, one (1) Pharmacist, one (1) registered nurse, two (2) non-affiliated community members, and the clinical research manager. Non-voting members shall minimally include the Chief Medical Officer and Washington Regional General Counsel and/or Compliance Officer.
12.9.11 Medical Ethics	The Medical Ethics Committee shall consist of five (5) Members appointed by the Chief of Staff, three (3) representatives from Nursing chosen by the Chief Medical Officer, one (1) representative from the chaplaincy program, the social services director, the director of hospice/home health, non-medical community members appointed by the Administrator, and the Chief of Medical Officer. The Washington Regional General Counsel shall serve in an advisory role to the committee. The committee will have co-chairpersons to include a member appointed by the Chief of Staff, and a nurse appointed by the Chief Medical Officer. The co-chairpersons shall be responsible for providing or arranging informal consultations, calling and conducting meetings and communicating results.
12.9.12 Physician Health Committee	The Physician Health Committee shall consist of a minimum of five (5) Members appointed by the Chief of Staff. The composition of the committee shall include a physician with extensive experience with impairment issues pertaining to professionals, a psychiatrist, a emergency medicine physician, and an anesthesiologist.
12.9.13 Pharmacy and Therapeutics	The Pharmacy and Therapeutics Committee shall consist of no fewer than three (3) Members of the Active Staff, one of whom is a member of the Pathology Service. The chairman shall be appointed by the Chief of Staff. Other standing members shall be the Administrator or his designee, the Director of Pharmacy, and the Chief Medical Officer.
12.9.14 Radiation Safety	The Radiation Safety Committee shall consist of no fewer than four (4) Members of the Active Staff who specialize in radiology or nuclear medicine, radiation oncology, internal medicine, and either hematology or pathology. At least one member will use radioactive material for diagnosis or treatment of humans. Other members of the committee shall be the director of radiology, the Chief Medical Officer, the section chief of nuclear medicine, and a representative of nursing. The radiation safety officer appointed by the radiation safety committee, will be an ex-officio member of the committee. The chairman shall be appointed by the Chief of Staff.
12. 9.15 Joint Conference Committee	The Committee shall consist of the following persons, with the following voting rights: The Chief Executive Officer (who shall serve as Chair of the Committee), four members of the Washington Regional Medical Center Board of Directors (as chosen by the Chairman of the Washington Regional Medical Center Board of Directors), four officers of the Medical Staff, specifically the Chief of Staff, Vice Chief of Staff, Chairman of the Department of Medicine and Chairman of the Department of Surgery, and one Member of the Active Medical Staff at-large as selected by the Medical Executive Committee. The Chief Medical Officer shall serve

	as an ex-officio, non-voting member.
12.9.16 Trauma Committee	The Trauma Committee shall consist of eight (8) active Medical Staff Members representing each of the following Services: Emergency Medicine, General Surgery, Neurosurgery, Orthopedics, Radiology, Anesthesia, the Medical Director for Critical Care Services, and the Medical Director for Trauma Services. The Medical Director for the Critical Care Service and Trauma Service shall fill the position reserved to each of those Services, respectively. Each Member shall serve for a period of two (2) years and shall be appointed by the Chief of Staff, except where a position is filled by virtue of a Member holding a specific medical directorship. The Committee Chairman shall be the Medical Director for the Trauma Service. Other voting members of the Committee shall include the Trauma Program Manager, Laboratory Director, Radiology Director, Pharmacy Director, Critical Care Director, ED Director, and OR Director. Non-voting, ex-officio members shall be the Chief Nursing Officer, Chief Medical Officer, Director of Quality Management, and Director of Physician Services. The Committee Chairman may appoint to the Committee such additional, non-voting members who are Washington Regional Medical Staff Members or employees as the Committee Chairman determines is necessary or advisable to the conduct and fulfillment of the Trauma Committee function.
12.9.17 Physician Peer Review Committee	The Physician Peer Review Committee ("PPRC") shall consist of five (5) Members of the Active Medical Staff, specifically the Vice Chair of the Department of Medicine, the Vice Chair of the Department of Surgery, the Vice Chief of Staff, a Member selected from the Department of Medicine, and a Member selected from the Department of Surgery. The PPRC may appoint such other Members of the Active Medical Staff as it deems necessary and advisable on an ad hoc basis to assist the PPRC in the performance of its duties.
12.9.18 Medical Records Committee	The Medical Records Committee shall consist of five (5) Members of the Active Medical Staff, two (2) of whom shall be selected by the Chair of the Department of Medicine, two of whom shall be selected by the Chair of the Department of Surgery, and one (1) of whom shall be selected by the Chief of Staff. The Director of the Health Information Services Department shall serve as an ex-officio, non-voting member.
12.9.19 Transfusion Committee	The Transfusion Committee shall consist of thirteen (13) members not less than seven (7) of who shall be Members of the active Medical Staff. The Medical Director for the Laboratory and the Medical Director of the Trauma Service shall be permanent members with the remaining five (5) active Medical Staff members being Members assigned to one of the following Services: Emergency Medicine, General Surgery, Anesthesia, Pulmonary, Obstetrics /Gynecology or Hematology/Oncology. Each Member shall serve for a period of two (2) years and shall be appointed by the Chief of Staff. The Committee Chairman shall be the Medical Director for the Laboratory. Other voting members of the committee shall include the Trauma Program Manager, Laboratory Director, ED Director, Blood Bank Supervisor ICU/CCU Director and a perfusionist member of the Allied Health Staff. Non-voting, ex-officio members shall be the Chief Nursing Officer, Chief Medical Officer and Clinical Informatist. The Committee Chairman may appoint to the Committee such additional, non-voting members who are Washington Regional Medical Staff Members or employees as the Committee Chairman determines is necessary or advisable to conduct and fulfillment of the Transfusion Committee function.

ARTICLE XIII

GENERAL STAFF MEETINGS, DUES AND FEES

13.1 Meetings of the General Medical Staff

13.1.1 Annual Meeting. The General Medical Staff shall meet at least once each year, on the first Monday in November. The November meeting shall serve as the annual meeting of the General Medical Staff.

13.1.2 Special Meetings. Special meetings of the Medical Staff may be called at any time by the Medical Executive Committee or Chief of Staff. The Chief of Staff must call a special meeting of the Medical Staff whenever he/she is presented with a written request for a special meeting that is signed by a least one-third of the Members of the Active category of the Medical Staff. No business will be transacted at any special meeting except that stated in the meeting notice.

13.1.3 Notice. Notice of the date, time and place of each Medical Staff meeting will be sent to each Member by regular mail, electronic mail, the Washington Regional Medical Center intranet, facsimile, or such other reasonable means as determined by the Medical Executive Committee, at least one (1) week prior to the scheduled date of the meeting.

13.2 Minutes

Minutes will be kept of all meetings of the General Medical Staff, the Medical Executive Committee, Departments, Services and standing Committees. Minutes shall be approved by the committee and signed by the chair.

13.3 Attendance Requirements

To foster professional interaction and awareness of items of general interest to the Medical Staff, as well as applicable standards and policies, each Member is encouraged to attend meetings of the General Medical Staff.

13.4 Dues and Fees

13.4.1 Annual Dues. The Medical Executive Committee shall be responsible for establishing the amount of annual dues for each category of the Medical Staff. No application for reappointment will be processed where the Member applicant has an outstanding annual dues balance.

13.4.2 Medical Staff Account. Medical Staff dues will be deposited into a Medical Staff account maintained at a local financial institution to be used, as appropriate, for the purposes of the Medical Staff. Expenditures from the Medical Staff account will be approved by the Medical Executive Committee.

13.4.3 Medical Staff Application Fee. When making initial application and reapplication for Medical Staff membership, the applicant will be charged an application fee as established by the Medical Staff Office from time-to-time as necessary to cover the actual costs incurred in processing an application for Medical Staff appointment.

ARTICLE XIV

CONFLICTS OF INTEREST

14.1 General Principals

14.1.1 All members of the Medical Staff and Allied Health Staff (hereafter collectively identified as "Practitioners" for purposes of this Article XIV only), especially Members serving in Medical Staff leadership positions, and Practitioners who are performing credentialing, peer review, or performance improvement functions, must be sensitive to potential conflicts of interest in performing their duties. An effective conflict of interest policy safeguards the integrity and reputation of Washington Regional, its Medical Staff and Allied Health Staff, by fostering the proper and unbiased conduct of professional

activities, providing a means for the disclosure and management of conflicts of interest, and describes situations that are prohibited.

14.1.2 A conflict of interest arises when there is a divergence between an individuals' private interests and his/her professional obligations to the Medical Staff, Washington Regional, patients and employees, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by considerations of personal gain – financial or otherwise.

14.1.3 Practitioners should conduct their affairs so as to avoid or minimize conflicts of interest, and must respond appropriately when conflicts of interest arise. A conflict of interest, in and of itself, is not grounds for any adverse actions with regard to a Practitioner's membership status or Clinical Privileges. However, a conflict of interest may require an individual to recuse himself or herself from participating in a discussion/determination of a given issue, and individuals with major or multiple potential conflicts of interest should consider whether their involvement in the relevant activity of the Medical Staff or Allied Health Staff is advisable. The Chief of Staff will have the ability and duty to limit or terminate any Practitioner's activities on behalf of the Medical Staff or Allied Health Staff if it is determined that real or potential conflicts of interest exist.

14.1.4 To ensure that the best interests of patients, the organization and the Medical Staff or Allied Health Staff are properly considered, Washington Regional requires Practitioners to disclose actual and potential conflicts of interest and to work cooperatively with Washington Regional to manage conflicts of interest.

14.2 Definitions

The following definitions apply for purposes of this Article XIV only:

14.2.1 "Conflict of Interest Involving a Competing Entity" means employment by, or serving as a board member, director or officer of, a competing hospital, health system, or other health care institution, other than Washington Regional.

14.2.2 "Conflict of Interest Involving Washington Regional" means employment by, or other contractual arrangement with, Washington Regional or any of its affiliates.

14.2.3 "Financial Interest" means that a Practitioner has, directly or indirectly, through business, practice or family:

A. an ownership or investment interest in any entity with which Washington Regional, or any of its affiliates, has a transaction or arrangement; or
B. a compensation arrangement with Washington Regional or any of its affiliates, or any individual or entity with which Washington Regional or any of its affiliates has a transaction or arrangement;

C. a potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which Washington Regional or any of its affiliates is negotiating a transaction or arrangement.

A Financial Interest is not necessarily a conflict of interest. A Practitioner who has a Financial Interest may have a conflict of interest only as determined under this Article XIV.

14.3 Conflicts Regarding Medical Staff Leadership

14.3.1 Any Medical Staff officer or any candidate for a position as an officer of the Medical Staff, who has an actual or potential Conflict of Interest Involving a Competing Entity or an actual or potential Conflict of Interest Involving Washington Regional shall make a complete and accurate disclosure of the existence and nature of the relationship. At the time of a Practitioner's nomination for election to a Medical Staff leadership position or appointment to a standing or special committee of the Medical Staff, the Practitioner will be required to complete a written conflict of interest disclosure statement and submit the same to the Medical Staff Office. Practitioners who fail to complete a written conflict of interest disclosure statement when required to do so in accordance with this Section 14.3.1 shall not be eligible to stand for election or shall be relieved of their Medical Staff leadership position, as applicable.

14.3.2 In the case of a Conflict of Interest Involving a Competing Entity, the Chief of Staff shall determine if a conflict of interest exists. The Vice Chief of Staff shall be responsible for reviewing any conflicts related to disclosure of the Chief of Staff. If an individual is found to have a Conflict of Interest Involving a Competing Entity, that individual may not be nominated, be elected, or hold office as a Medical Staff officer or serve on a standing or special committee of the Medical Staff.

14.3.3 In the case of a Conflict of Interest Involving Washington Regional, any candidate for a position as an officer of the Medical Staff or appointment to a standing or special committee of the Medical Staff shall disclose the fact of such arrangement to the Chief of Staff who shall decide how this information shall be disseminated to the Medical Staff in advance of the General Medical Staff meeting at which nominations may be submitted.

14.4 Internal Conflicts of Interest

14.4.1 The following are common situations that are representative, but not all inclusive, of actual or potential conflict of interest situations:

A. Influence on purchases of services, equipment, instruments or materials for Washington Regional from businesses in which the Practitioner, or an immediate family member, has a financial interest.

B. Influence upon the negotiation of contracts between Washington Regional and organizations with which the Practitioner, or immediate family member, has consulting or other significant relationship, or will receive favorable treatment as a result of such influence.

C. Acceptance of compensation or free services from a vendor, service provider, or contractor of Washington Regional, when the Practitioner is in a position to determine or influence Washington Regional's purchases from those persons or entities.

D. Improper disclosures or use of patient or Washington Regional information for personal gain.

E. Participating in a Medical Staff proceeding concerning a direct competitor of the Practitioner, a member of the same group practice as the Practitioner, or an individual with whom the Practitioner has a history of personal conflict.

14.4.2 Whenever a Practitioner has a potential or actual conflict of interest as described in Section 14.4.1, the Practitioner must disclose the existence of the conflict and all material facts related to his or her interest. Failure to make such a disclosure shall result in the disqualification of the Practitioner from further participation in the matter at hand and m ay, depending on the circumstances, result in disciplinary or corrective action pursuant to these Bylaws.

14.4.3 In any instance where a Practitioner has or reasonably could be perceived to have a conflict of interest in any matter that comes before the Medical Staff, the Medical Executive Committee, a Department, Service or other committee, the Practitioner shall not participate in the discussion or vote on the matter and shall absent himself or herself from the meeting during that time. The Practitioner may be asked and may answer any questions concerning the conflict before leaving. The Medical Staff officers, Department or Service Chair, or other committee chair may routinely inquire, prior to initiating discussion, as to whether any Practitioner has any conflict of interest regarding the matters to be addressed.

14.4.4 The Chief of Staff or the applicable Department, Service or other committee chair has the authority to make a final determination as to how best to manage the situation, including recusal of the Practitioner, if necessary.

14.4.5 Where disclosure of a potential or actual conflict of interest occurs during a meeting of the Medical Executive Committee, Department, Service or other committee of the Medical Staff, the chair of such committee shall consider whether the Practitioner's presence would inhibit full and fair discussion of the issue or otherwise impact the recommendation. In the event it is determined that there is such a potential or actual conflict of interest, the Practitioner shall be recused from further participation in the meeting and shall leave the meeting room prior to the final deliberations and vote. Prior to leaving, the Practitioner may provide information that he or she thinks relevant to the issue at hand. The minutes shall reflect the disclosure of the conflict of interest and the fact that the Practitioner has left the meeting.

14.4.6 No Practitioner has a right to compel the disqualification of another Practitioner based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Chief of Staff or other Medical Staff Officer or Member who is chairing the meeting, as guided by this Article XIV.

ARTICLE XV

ORGANIZED HEALTH CARE ARRANGEMENT

Washington Regional, together with all Members of the Medical Staff, the House Staff and Medical Student Staff, and the Allied Health Staff (collectively, for purposes of this Article XV only, the “"Washington Regional Staff”),"), constitute an Organized Health Care Arrangement ("OHCA") under the Privacy Regulations implemented pursuant to the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. Parts 160 and 164), and each member of the Washington Regional Staff will abide by the terms of this joint notice with respect to Protected Health Information (as that term is defined at 45 C.F.R. §160.103) he may receive in connection with his participation in professional activities of the OHCA. Washington Regional and the Washington Regional Staff may share Protected Health Information with each other as necessary to carry out treatment, payment or health care operations functions relating to the OHCA.

ADOPTION

Adopted and approved by the Medical Staff on February 12, 2013.
Adopted and approved by the Board of Directors on February 19, 2013.
Adopted and approved by the Board of Directors on November 18, 2014
Adopted and approved by the Medical Staff on March 14, 2016.
Adopted and approved by the Board of Directors on March 15, 2016
Adopted and approved by the Medical Staff on November 14, 2016.
Adopted and approved by the Board of Directors on November 15, 2016
Adopted and approved by the Medical Staff on April 17, 2017.
Adopted and approved by the Board of Directors on April 18, 2017.