KETTERING HEALTH NETWORK

MEDICAL STAFF BYLAWS

Medical Staffs of:
Kettering Medical Center with Sycamore Medical Center and Troy Hospital
Grandview Medical Center with Southview Medical Center
Indu and Raj Soin Medical Center with Greene Memorial Hospital
Fort Hamilton Hospital

Effective: November 7, 2019

Revised: April 24, 2020 (Medical Staff); May 1, 2020 (Board); November 16, 2021 (MEC); February 3, 2022 (Board)

Copies of Medical Staff Bylaws, Rules and Regulations, Policies and Governing Manuals are available through Medical Staff Services Department upon request of any Medical Staff member.

TABLE OF CONTENTS

DEFINITIONS

Affiliate Hospital means a Kettering Health Network wholly-owned hospital, now comprised of Kettering Medical Center with Sycamore Medical Center and Troy Hospital, and Grandview Medical Center with Southview Medical Center, Fort Hamilton Hospital, Indu & Raj Soin Medical Center with Greene Memorial Hospital.

Appointee means a practitioner who has been granted membership to the Medical Staff as defined by the assigned staff category.

Board of Directors, Board of Trustees or **Board** means the Hospital's governing body which holds ultimate responsibility for the Hospital.

CCO or **Centralized Credentialing Office** means the Kettering Health Network Centralized Credentialing Office that acts as an appointed authorized agent of the Credentials Committee of each Hospital to conduct certain credentialing and verification functions for the Hospital as referenced in the Bylaws.

CEO or President or **President/CEO** means the individual appointed by the Board to act on its behalf in the overall management of the Hospital. The Medical Staff may rely upon all actions of such individual as being authorized by the Board.

Chief Medical Officer or CMO means the practitioner appointed by the Board or designee, in conjunction with the Medical Staff, to work with the Medical Staff leadership on matters of medical administration and quality oversight and other duties as assigned.

CMO means the Chief Medical Officer.

Chief of Staff means the individual elected by the Medical Staff to be the spokesperson for the Medical Staff and is the chair of the Medical Executive Committee and is the Chief Executive Officer of the Medical Staff.

Clinical Privileges or **Privileges** means the authorization granted by the Board to a Physician, Podiatrist, Dentist, Psychologist or APP to provide specific patient care services at the Hospital within defined limits.

Clinical Department or Department means a group of Appointees who share a specialized commonality or clinical perspective and who have been established and/or recognized by the Medical Executive Committee as a clinical organized division of the Medical Staff. Appointees are assigned to a Clinical Department as delineated in the Credentials Policy Manual.

Conflict of Interest means any personal, professional, financial or business circumstance or relationship that either is in direct conflict with one's official duties, loyalties, activities and/or responsibilities on behalf of the Medical Staff, or may be perceived as such, so that such competing interest may inappropriately influence one to act in his/her own behalf rather than in the best interest of the Medical Staff.

Department Chair means the individual selected and recommended by members of a clinical division of the Medical Staff to manage the affairs of such division and appointed by the Board.

Dentist means an individual who has received a doctor of dental medicine or doctor of dental surgery degree and is currently licensed to practice Dentistry and whose practice is in the area of oral and maxillofacial surgery or the area of general Dentistry or a specialty thereof.

Department or Clinical Department means a group of Appointees who share a specialized commonality or clinical perspective and who have been established and/or recognized by the Medical Executive Committee as a clinical organized division of the Medical Staff. Appointees are assigned to a Clinical Department as delineated in the Credentials Policy Manual.

Emergency Call means a process whereby patients may be provided medical care services by a Practitioner scheduled to be available to provide that service and who is capable of admitting and/or directing toward admission, and providing the level of medical care required during a patient's hospitalization. Emergency Call also means a Hospital wide emergency alert (including the Emergency Department) formally activated by the Administrator on Call (AOC) pursuant to the Hospital's Disaster Plan.

Exclusive Contract means a contract between the Hospital and a member or members providing for the exclusive delivery of certain services by the member or members.

Ex Officio means appointment to serve as a member of a body by virtue of an office or position held. Ex Officio members shall not be counted for purposes of determining a quorum nor shall they have voting rights, unless otherwise expressly stated.

Federal Health Program means Medicare, Medicaid, TriCare, CHIPS or any other federal or state program providing health care benefits that is funded directly or indirectly by the United States government.

Focused Professional Practice Evaluation (FPPE) means the process of providing an evaluation of a privilege-specific competence of a practitioner as it relates to the performance of privileges newly granted to a practitioner or as the result of unexpected and/or unacceptable performance and/or outcomes

GVMCS means Grandview Medical Center System including Grandview Medical Center with Southview Medical Center.

Good Standing means a Practitioner, who, during the current term of appointment, with or without the grant of Privileges, has an absence of disciplinary actions and has maintained qualifications for Medical Staff Membership and assigned category. If a Practitioner has been suspended during this time frame for failure to comply with the Hospital's policies or procedures regarding medical records and has subsequently taken appropriate corrective action, such suspension shall not adversely affect the Practitioner's Good Standing status. A Practitioner who is voluntarily not exercising his/her appointment and/or Privileges shall be considered to be in Good Standing.

Hospital means an acute care hospital of Kettering Health Network (including all inpatient and outpatient departments and locations and ambulatory care facilities), to which these Bylaws apply, as the context requires.

Investigation means the formal, focused and purposeful gathering of information, records and other data with respect to the clinical competence, professional conduct and/or practice patterns of a Practitioner for the purpose of determining whether to take or recommend a professional review action. Only the MEC may initiate a formal Investigation. The routine functionings of Medical Staff of its committees, including but not limited to informal or routine inquiries or remediation activities, or of the Hospital's quality assessment and performance improvement activities, or of risk management activities, or of resource management departments or committees, and/or any and all discussions with a Practitioner relating to such matters do not constitute an Investigation unless so defined in these Bylaws..

Joint Conference Council or **Joint Conference Committee** or **JCC** means the committee that serves as an official liaison between the Medical Staff, the Board and the President/CEO, with its composition and duties as described in the Organization and Functions Manual.

KETTERING or **KHN** means Kettering Health Network.

KHN or **KETTERING** means Kettering Health Network.

KMCS means Kettering Medical Center System" or "KMCS" means Kettering Medical Center, Sycamore Medical Center, and Kettering Health Network Troy Hospital which have elected to have a Unified Medical Staff.

Manual means those documents approved by the Medical Executive Committee and the Board which serve to implement and supplement the Medical Staff Bylaws including, but not limited to, the Medical Staff Credentials Policy Manual ("Credentials Policy Manual") and the Medical Staff Organization and Functions Manual ("Organization and Functions Manual") which contains the Rules and Regulations of the Medical Staff.

Medical Executive Committee or **MEC** means the executive committee of the Medical Staff.

Medical Staff means the formal organization of all allopathic Physicians, osteopathic Physicians, Dentists (including oral maxillofacial surgeons), Podiatrists, and Psychologists who have obtained appointment status at the Hospital (including all campuses, provider-based locations, satellites, remote locations, etc.) with such responsibilities, prerogatives, and privileges as defined in the category to which each has been appointed. Each KHN Hospital has an individual Medical Staff.

Medical Staff Bylaws or **Bylaws** means the articles and amendments that constitute the basic governing documents of the Medical Staff.

Medical Staff Services means the Hospital administrative department that provides support services to the Medical Staff.

Medical Staff Year means the period from January 1 to December 31 each year.

Member means a member of the Medical Staff.

Non-Physician Practitioner ("NPP") or **Advanced Practice Practitioner ("APP")** or **Allied Health Practitioner ("AHP")** means an individual other than a licensed Physician (osteopathic or allopathic), Podiatrist, Dentist, or Psychologist who functions in a medical support role or who exercises independent judgment within the area of his or her professional competence and is qualified to render direct or indirect medical, surgical, nursing, dental, podiatric, or psychological care under the supervision of or in collaboration with a Practitioner who has been accorded privileges for such care in the Hospital. NPPs may include, but are not limited to, licensed physician assistants ("PA"), licensed advanced practice registered nurses ("APRN"), or other individuals whose scope of practice has been recognized by the Hospital.

NPP means non-physician practitioner.

Oral Surgeon or **Maxillofacial Surgeon** means a practitioner who has successfully completed an accredited post-graduate/residency program in oral/maxillofacial surgery.

Ongoing Professional Practice Evaluation (OPPE) means the process of providing continuous evaluation of practitioners' performance by each applicable department or committee of the medical staff with reports communicated on a routine basis. Areas of focus include, but may not be limited to, any areas of expected competency regarding patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice as well as other performance and outcomes as may be applicable.

Patient Encounter means (a) in the inpatient setting, an inpatient admission, consultation (resulting in not less than a progress note), or surgery/invasive procedure; (b) in the outpatient setting, treatment or consultation resulting in not less than a progress note, or surgery/invasive procedure; or (c) treatment in the Emergency Department resulting in not less than a progress note.

Physician means an individual who is licensed by the State Medical Board of Ohio to practice allopathic medicine and surgery (M.D.) or osteopathic medicine and surgery (D.O.).

Podiatrist means an individual who is licensed by the State Medical Board of Ohio to practice podiatric medicine and surgery (D.P.M.).

Practitioner means, unless otherwise provided, Physician, Dentist, Podiatrist or Psychologist.

Prerogative means a participatory right granted by the Medical Staff subject to the ultimate authority of the Board, and to the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

President or **President/CEO or CEO** means the individual appointed by the Board to act on its behalf in the overall management of the Hospital. The Medical Staff may rely upon all actions of such individual as being authorized by the Board.

Privileges or **Clinical Privileges** means the authorization granted by the Board to a Physician, Podiatrist, Dentist, Psychologist or NPP to provide specific patient care services at the Hospital within defined limits.

Professional Liability Insurance means insurance coverage acceptable to the Board as the Board may determine from time to time by an insurance company licensed in the United States or having coverage by a company who has an underwriting agreement with a licensed U.S. insurance company to assure adequate reserves for payment of claims.

Professional Review Activity means an activity of a health care entity (as defined in the federal Health Care Quality Improvement Act of 1986 (HCQIA) and sections 2305.25 et.seq. of the Ohio Revised Code) with respect to a practitioner: to determine whether such Practitioner may have Clinical Privileges with respect to, or membership in, the health care entity; or to determine the scope or conditions of such privileges or membership; or to change or modify such privileges or membership; or for purposes as set forth in the Ohio Revised Code.

Professional Review Body means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes, but is not limited to, any committee of the medical staff of such an entity when assisting the governing body in a professional review activity, and other committees as defined by section 2305.25 and as used in sections 2305.251 to 2305.253 of the Ohio Revised Code.

Rules & Regulations means the compendium of rules and regulations promulgated by the Medical Staff as approved by the Board to govern specific administrative and patient care issues that arise at the Hospital.

Special Notice means a written notification personally delivered, or sent by a commercially reasonable means of receipted delivery, including but not limited to, United States certified or registered mail, return receipt requested, postage prepaid, to the address(es) of the intended recipient as reflected in the records of the Hospital (using reasonable efforts to identify a correct address, as necessary).

Telemedicine means the practice of medicine as defined by Ohio law by qualified physicians from one site to another distant site through the use of any means of communication, including oral, written or electronic communications.

In General:

Words used in these Bylaws shall be read as the singular or plural, as the content requires. Whenever a personal pronoun is used, it shall be interpreted to refer to persons of either gender. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

When an individual is authorized to perform a duty by virtue of his or her position, then the term shall also include the individual's designee.

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

ARTICLE 1

PREAMBLE

WHEREAS, Kettering Health Network ("Kettering" or "KHN") is a not-for-profit network that includes separately certified acute care hospitals[1] located in Southwest Ohio, each being a non-profit corporation organized under the laws of the State of Ohio, all operating as a clinically integrated health care arrangement; and

WHEREAS, independent, non-profit and self-governing medical staffs serve the hospitals within Kettering with the purpose of providing patient care, education and research; and

WHEREAS, the Medical Staff of each Kettering Hospital has separately and voluntarily adopted and approved this single, aligned Medical Staff Bylaws document in order to organize itself and establish methods of self-governance to carry out the herein delegated duties, with unique features and/or differences at individual Hospitals, if any, being indicated herein by footnote; and

WHEREAS, should the Board elect to have a unified and integrated medical staff organization and structure for certain or all of its member hospitals, after determining that such a decision is in accordance with all applicable State and local laws, the medical staff of each separate Hospital retain the right to vote on whether that Hospital's medical staff should participate in or opt out of such unified medical staff structure by following the procedures set forth in these Bylaws; and

NOW THEREFORE, to discharge the duties and responsibilities in the Hospital in an orderly fashion, the Medical Staff practicing in each Kettering Hospital shall function and act in accordance with the following Bylaws and procedures which have been adopted by and are enforced by each of the Medical Staffs, and have been approved by the Board. The Hospital management of each Hospital has agreed and shall cooperate with and assist the Appointees in each Hospital in the accomplishment of this responsibility to that Hospital.

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[1] Ohio acute care hospitals are Kettering Medical Center (KMC) in Kettering, Sycamore Medical Center (SMC) in Miamisburg, and Kettering Health Network Troy Hospital (Troy) in Troy (collectively, KMCS); Grandview Medical Center in Dayton with Southview Medical Center ("SV") in Washington Twp. (collectively "GMC" or "GV"); Indu and Raj Soin Medical Center in Beavercreek with Greene Memorial Hospital in Xenia ("Greene") (collectively "Soin"); and Fort Hamilton Hospital in Hamilton ("FHH").

ARTICLE 2.

PURPOSE

These Bylaws, as adopted or amended, create a system of mutual rights and responsibilities between Practitioners and the Hospital, and are approved by and subject to the corporate authority of the Board in those matters where the Board has ultimate legal responsibility. These Bylaws are not intended to be and are not to be construed as a contract.

It is the intent and purpose of these Bylaws that the initiation and conduct of professional review actions hereunder comply in all material respects with the provisions of S 412 of the Health Care Quality Improvement Act of 1986 and the Ohio Peer Review Statute (ORS 2305.25 et. seq.).

The Board wishes to delegate to the Clinical Departments and Sections, to the committees of the Medical Staff, and specifically to certain officers of the Staff, Chairs of those Clinical Departments and Sections and members of those committees, the duties and responsibilities for monitoring the quality of medical care in the Hospital and reporting thereon to the Board, and the authority and responsibility to make recommendations to the Board concerning an applicant's appointment or reappointment to the Medical Staff of the Hospital and the Clinical Privileges such applicant shall enjoy in the Hospital; and the Medical Staff desires to organize itself and establish methods of self-governance to carry out these delegated duties.

The purposes of this Medical Staff are to:

(a) Provide a mechanism for accountability to the Board through defined organizational components and positions for the appropriateness of patient care services and the professional and ethical conduct of each Practitioner appointed to the Medical Staff and each Practitioner/NPP granted Privileges at the Hospital, to the end that patient care provided at the Hospital is maintained at that level of quality and efficiency which is commensurate with, or superior to, generally recognized standards of care.

(b) Serve as the collegial body through which Practitioners/NPPs may, as applicable, obtain Prerogatives and Privileges at the Hospital, fulfill their obligations of Medical Staff appointment and/or Privileges at the Hospital, and practice in an environment that promotes quality and efficient patient care.

(c) Provide on behalf of the Hospital an appropriate educational setting and to maintain high scientific and educational standards for continuing medical education programs for Practitioners.

(d) Provide an orderly and systematic means by which Appointees can give input to the Board and President/CEO on medico-administrative problems and on the Hospital's policy-making and planning processes.

(e) Initiate, maintain, and enforce the Medical Staff Bylaws, other related Medical Staff governance documents and policies for self-governing of the Medical Staff.

(f) Assume accountability to the Board for the quality of medical care provided by an Appointee/Practitioner to the patients, which may include the following:

- Acting on reports of clinical services and committees of the Medical Staff;
- Providing reports and recommendations to the Board regarding Medical Staff appointments, reappointments, and privilege delineations;
- Providing reports and/or recommendations to the Board regarding Medical Staff behaviors that result in suspension or other corrective action, and any fair hearing results;
- Providing reports to the Board of organizational proposals including, Bylaws and other related manuals of the Medical Staff and Medical Staff Officers;
- Assuming accountability to the Board for the findings from reviewing and evaluating on a continuing basis such Clinical Privileges as have been granted to Appointees/Practitioners via periodic and ongoing professional practice evaluations of their clinical work; and
- Collaborating with administration and the Board regarding institutional planning, budgeting, and the appropriate utilization of available resources.

(g) Discharge those duties and responsibilities delegated to it by the Hospital Board to make recommendations to the Board concerning any appropriate action that may be necessary in connection with any Appointee/Practitioner to the Medical Staff to end that there shall be a high level of professional performance by all persons authorized to practice in the Hospital.

ARTICLE 3.

MEDICAL STAFF APPOINTMENT

SECTION 3.1. NATURE OF MEDICAL STAFF APPOINTMENT

The Board has final authority for appointments and reappointments to the Medical Staff based upon the recommendations of the Medical Staff. Applications are processed in accordance with the Credentials Policy Manual, based upon the professional criteria set forth in this Article. Appointment to the Medical Staff and/or granting of Privileges at the Hospital is a privilege that shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to the Medical Staff is separate and distinct from a grant of Privileges. A Practitioner can be a Medical Staff Appointee with or without Privileges, or be granted Privileges without a Medical Staff appointment. A Practitioner who is granted Medical Staff appointment is entitled to such Prerogatives and is responsible for fulfilling such obligations as set forth in these Bylaws and the Medical Staff category to which the Practitioner is appointed. Medical Staff appointment shall confer only such Privileges as are granted in accordance with these Bylaws. A Practitioner who is granted Privileges at the Hospital is entitled to exercise such Privileges and is responsible for fulfilling such obligations as set forth in these Bylaws and the applicable Privilege set. If non-physician practitioners are granted Privileges only, such Privileges shall be in accordance with Ohio law, rules and regulations, and scope of practice; and such NPPs shall also function under the Bylaws, rules and regulations of the Medical Staff. The Board and the Medical Staff shall evaluate and exercise oversight of such practitioners just as it would for those Practitioners appointed to its Medical Staff, using the same credentialing and privileging process. Otherwise, the credentials policies and procedures for NPPs are as described in the Credentials Policy Manual, and no provisions of the Bylaws apply to NPPs unless expressly stated.

A Medical Staff member is not an employee or an independent contractor of the Hospital, unless such relationship is established in writing between such Member and the Hospital.

KHN has established a Centralized Credentialing Office (CCO) to serve as a central credentials information collection and verification resource with respect to Practitioners who apply for Medical Staff Membership at the Hospital. Applications for appointment, reappointment and privileges are submitted to the CCO which reviews such for completeness, collects required information, performs primary source verification, and submits its completed application with supporting documentation to the Medical Staff Services Department which shall perform further primary source verification before submitting the application to the applicable Department Chair, the Credentials Committee, and the Medical Executive Committee for review and action, subject to Board approval. All recommendations to the Medical Executive Committee by the Credentials Committee will be made within 60 days of receipt of a completed application and will be based on individual Practitioner's qualifications and competency at the time privileges are requested. The Board shall act on appointments, reappointments and/or privileges in accordance with Ohio law, scope of practice laws, and these Bylaws and Rules and Regulations only after there has been a recommendation from the MEC. The time frame to complete this process is 120 days. Verified credentialing information may be shared within KHN to the extent permitted by law, regulation,

and accreditation standards; and is protected from disclosure. Any misrepresentation or misstatement in an Application, or omissions from an applicant may be cause for the application to immediately become null and void, thus resulting in ineligibility for membership. In the event an application is deemed null and void or a misrepresentation or misstatement is discovered with regard to a current Member or a Practitioner holding Privileges only, such discovery may result in immediate termination of membership/Privileges upon the recommendation of the MEC to, and the approval of, the Board without the right to a fair hearing and appeal. In such event, the Practitioner may not reapply for one year.

SECTION 3.2. QUALIFICATIONS FOR APPOINTMENT

3.2.1. In General.

Only Physicians, Dentists, Psychologists, or Podiatrists, holding a valid and unsuspended license to practice in the State of Ohio; who can satisfactorily document their background, licensure, experience, training/education, judgment, individual character, demonstrated current competence; ability to exercise the privileges requested with or without a reasonable accommodation (health status); adherence to the recognized standards of medical and professional ethics; good personal and professional reputation; mental and emotional stability; Specialty Board Certification to the extent required by these Bylaws; adequate professional liability insurance coverage as determined by the Board; and the ability to work cooperatively with and relate to others in a cooperative, professional, non-disruptive manner that is essential for maintaining a hospital environment appropriate to quality and efficient patient care to assure the Medical Staff and the Board that any patient treated by them in the Hospital will be given a high quality of health care, shall be qualified for appointment to the Medical Staff. Any criminal records check that is performed must not evidence convictions of offenses that could result in a loss of his/her license to practice in the State of Ohio, and shall act to disqualify an applicant from consideration for appointment or reappointment to the Medical Staff. No Practitioner, including those in a medico-administrative position by virtue of a contract with the Hospital, shall treat or otherwise provide medical care to a patient in the Hospital unless the Practitioner is an Appointee and/or has been granted Privileges to do so. No Practitioner shall be entitled to appointment to the Medical Staff or to exercise privileges in the Hospital merely by virtue of the fact that the Practitioner is duly licensed to practice medicine, dentistry, psychology, or podiatry in this or any other state; or solely based upon certification, fellowship or membership in a specialty body or society; or that the Practitioner had in the past, or now has, professional appointment or privileges at another hospital. If it is determined that the informational elements contained in the Application Request Form indicate that the applicant desires to primarily provide a service not available within the Hospital or one that is the subject of an exclusive agreement, the applicant shall not be issued an application and shall be so notified of the reasons; but such notice does not constitute a denial of appointment and shall not give rise to any due process rights or right of review under the Bylaws.

3.2.2. Eligibility.

(a) Proof of continuous maintenance of professional liability insurance consistent with the amount specified by the Board. This requirement includes obtaining tail coverage or nose coverage, as applicable, in order to provide continued coverage for any gaps between policies. The Hospital shall be notified in writing of any change in or termination of such insurance coverage while a member or holder of Privileges of the Medical Staff. Failure to maintain continuous, acceptable insurance coverage shall result in automatic suspension or restriction of affected Privileges, with no restoration unless for good cause shown. If coverage requirements are not met for more than 60 days, Privileges will automatically terminate on the 61st day unless a waiver has been requested in connection with changed circumstances and is awaiting final action.

(b) Proof of current Ohio licensure or registration and verification of not currently being excluded for cause by the secretary of Health and Human Services from participation in any Federal Health Program as a provider, pursuant to Sec. 1128 (42 U.S.C. 1320a-7).

(c) For initial appointment only, of a Physician or to the active or courtesy Medical Staff category, documentation of experience and training, including completion of a residency/fellowship approved by Accreditation Council for Graduate Medical Education (ACGME"), American Board of Medical Specialties ("ABMS") or American Osteopathic Association ("AOA").

(d) For initial appointment only, of a Physician or Podiatrist to the Active or Courtesy Medical Staff category, applicants must have within the last six (6) years (or within such timeframe as may then be required by the particular certifying board) completed a post-graduate training program which qualified the applicant to seek certification (within his/her respective specialty) or possess current board certification, within respective specialty by a member board of the ABMS, AOA, American Board of Oral & Maxillofacial Surgery ("ABOMS"), American Board of Podiatric Surgery ("ABPS"), or the American Board of Podiatric Primary Medicine and Orthopedics (ABPPMO). Those applicants (excluding Dentists and Psychologists) who do not possess current board certification at initial appointment must obtain board certification within six (6) years of completing his/her residency program (or within such timeframe as may then be required by the particular certifying board) to maintain appointment to the Medical Staff and Privileges.[1]

(e) Applicants for reappointment, after achievement of initial board certification, are not required to maintain board certification unless otherwise stated as required in the

[1] The requirements of this paragraph shall not be applicable to Physicians and Podiatrists who have been on the Medical Staff of: (i) KMC since January 1, 1996; or (ii) GMC since January 2, 2002; or (iii) FHH since July 1, 2010 or otherwise having been excused by the FHH Board. When applicable, for GMC, such Board Certification is required for initial appointments within 6 years of completing residency or after appointment (whichever is first). For FHH, Board Certification in his/her specialty is required for initial appointments or within 6 years of completing residency or receiving membership or privileges. Only to the extent permitted by then-current Medicare Conditions of Participation and then-current accreditation requirements may exceptions be made, and then only by the Board in collaboration with the Medical Staff pursuant to the standard application process for good reason shown

respective clinical privileges profile, or as required to qualify as an officer of the Medical Staff, or as may otherwise be stated in these Bylaws and/or governing manuals.[1]

(f) Ohio license and federal registration to dispense controlled substances if required to exercise requested Privileges.

(g) All applicants must demonstrate good moral character.

(h) Applicants for Medical Staff appointment and/or Privileges must agree to fulfill, and fulfill, the responsibilities, as applicable, set forth in the Medical Staff governing documents.

3.2.3. Nondiscrimination.

Neither the Hospital nor its Medical Staff will discriminate in granting Medical Staff appointment or privileges on the basis of illegal discrimination, including sex, race, creed, national origin, and handicap or other considerations not impacting the applicant's ability to discharge the privileges for which he/she has applied.

SECTION 3.3. CONDITIONS AND DURATION OF APPOINTMENT AND REAPPOINTMENT

3.3.1. Appointment and Reappointment.

Initial appointment and reappointment to the Medical Staff and the granting/regranting of Privileges shall be made by the Board of Directors and as otherwise provided in these Bylaws and Credentials Policy Manual, as may be amended. The Board shall act on appointment, reappointment, and Privileges only after there has been a recommendation from the Medical Executive Committee or as otherwise provided in these Bylaws or its Credentials Policy Manual. All individuals and committees required to act on an application for Medical Staff appointment (as further described hereunder at Section 3.1) must do so in a timely manner and, except for good cause, each application should be processed within one hundred twenty (120) days from receipt of an application determined to be complete. Temporary Privileges for a new applicant, a new procedure, locum tenens privileges, or to fulfill an important patient care need are requested and granted in accordance with the procedure outlined in the Credentials Policy Manual and may not exceed one hundred twenty (120) days. In the event that an applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment may be granted pending the completion and resolution of the investigation and any related hearing process.

3.3.2. Term.

[1] The requirements of this paragraph shall not be applicable to Physicians and Podiatrists who have been on the Medical Staff of KMC since January 1, 1996.

Appointments to the Medical Staff and grants of Privileges will be for no more than twenty-four (24) calendar months. Appointments and/or grants of Privileges for a period of less than twenty-four (24) calendar months shall not be deemed adverse.

3.3.3. Prerogatives.

Appointment to the Medical Staff shall confer on the Appointee only prerogatives as have been granted in accordance with these Bylaws.

3.3.4. Evaluation Exam.

If the MEC or Board has reason to believe that a physical and/or mental condition of a Member of, or an applicant to, the Medical Staff is impairing such individual's ability to provide quality patient care, such Practitioner may be required to submit to an evaluation of his/her physical and/or mental status by an examining physician(s) acceptable to the MEC and to the Board as a prerequisite to: further consideration of his/her initial application or reappointment to the Medical Staff; the continued exercise of previously granted privileges; and/or maintenance of Medical Staff membership. Such Practitioner may also be referred to the Medical Staff Wellness Committee for further evaluation.

SECTION 3.4. MEDICAL STAFF DUES

3.4.1. Dues.

Annual Medical Staff dues, if any, shall be governed by the most recent action recommended by the Medical Executive Committee and adopted at a regular or special Medical Staff meeting. The Chief of Staff shall notify each Appointee, in writing, of any contemplated change in Medical Staff dues at least twenty-one (21) days before the meeting at which voting on such proposed change is to take place.

3.4.2. Exceptions.

If dues are required, Medical Staff Appointees are not required to pay dues if they are "Associate Medical Staff – Membership Only Retired", or "Associate Medical Staff – Membership Only Honorary".

3.4.3. Payment.

Dues, if required, shall be due and payable within thirty (30) days of written request. A failure to pay Medical Staff dues within the required time frame shall be construed as an automatic suspension from the Medical Staff.

SECTION 3.5. ETHICAL REQUIREMENTS

A Practitioner who accepts appointment to the Medical Staff and/or Privileges agrees to act in an ethical, professional, and courteous manner consistent with the Hospital's code of ethics as well as any applicable ethics of the Practitioner's professional association and related Hospital and Medical Staff Bylaw provisions and policies.

No Appointee shall either receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services that is in violation of applicable State and federal laws and regulations.

SECTION 3.6. HIPAA

As applicable, all members of the Medical Staff shall abide by the terms of the Notice of Privacy Practices prepared and provided to patients as required by the federal Health Insurance Portability and Accountability Act of 1996, as may be amended from time to time. Such notice is available in the Medical Staff Services Department or online.

SECTION 3.7. RESPONSIBILITIES OF APPOINTMENT & EXERCISE OF PRIVILEGES

Each Appointee may independently direct the care of his/her patients within the scope of the Appointee's Privileges subject to the Medical Staff Bylaws and any Rules and Regulations and applicable policies, the Organization and Functions Manual, and the Credentials Policy Manual, and any other applicable governing documents as they now exist and as amended. Each Appointee is subject to review as a part of the Hospital's performance improvement activities. No Appointee is responsible for the actions of other Appointees or APPs unless such individual is practicing in collaboration with or under the supervision of such Appointee. No Appointee is responsible for the actions of Hospital employees unless the Appointee contracts, in writing, to undertake such responsibility. Appointees shall participate appropriately as peer reviewers in Medical Staff peer review activities as assigned, including proctoring, records review, application review, hearing and other committee participation, utilization management, and/or other peer review activities as reasonably assigned.

SECTION 3.8. QUALIFICATIONS/RESPONSIBILITIES FOR APPOINTMENT WITHOUT PRIVILEGES

Practitioners appointed to non-privileged Medical Staff categories shall meet such qualifications and fulfill such obligations as set forth in the applicable Medical Staff category, and/or as otherwise recommended by the MEC and approved by the Board.

SECTION 3.9. CONTRACTUAL ARRANGEMENTS

The Board, after formal documented consultation with the MEC, may determine that an exclusive contractual arrangement between an individual Appointee, group of Appointees, or in some instances, an entire Department, is the preferred manner to deliver a service or accomplish a function. In all instances, Appointees to the Medical Staff who are a party to such negotiated contracts or employment relationships with the Hospital must achieve and maintain Medical Staff membership and/or Privileges by the same procedures described in these Bylaws. Unless the written contractual arrangement specifically provides otherwise, or unless otherwise required by law, Privileges that are granted hereunder that are exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate upon termination or expiration of such Appointee's contract or agreement with the Hospital, without the right of access to the review, hearing and appeal procedures of these Bylaws. Appointees who subcontract with other practitioners or entities that contract with the Hospital to provide clinical services may lose

Privileges granted pursuant to an exclusive or semi-exclusive arrangement if their relationship with the contracting practitioner or entity is terminated, or if the Hospital and the contracting practitioner's or entity's agreement or exclusive relationship is terminated. The Hospital may enforce such an automatic termination even if the subcontractor's agreement fails to recognize this right. To the greatest extent permitted by law, contracts between practitioners and the Hospital shall prevail over these Bylaws and the Rules and Regulations, except that such contracts may not reduce any hearing rights hereunder when an action will be taken that must be reported to the Medical Board of Ohio or to the federal National Practitioner Data Bank. There shall be no conflict between the Medical Staff Bylaws and specific contract or employment terms. The Board is responsible for services furnished in the Hospital whether or not such are furnished under contracts.

SECTION 3.10. CLINICAL PRIVILEGES IN GENERAL.

Appointment to the Medical Staff confers on the Appointee only such Clinical Privileges as have been granted by the Board and requires that each applicant assume such reasonable duties and responsibilities as the Board or the Medical Staff shall require. In any emergency, however, any Appointee to the Medical Staff shall be permitted to exercise emergency privileges as described in the Credentials Policy Manual. When the emergency condition no longer exists, the care of the patient will be transferred to a Member of the Medical Staff with the appropriate Clinical Privileges as determined by the applicable Chair of the Clinical Department or Section. The Hospital grants disaster privileges as described in the Credentials Policy Manual to volunteer licensed independent practitioners only when the emergency operations plan has been activated in response to a disaster and the Hospital is unable to meet immediate patient needs and the President/CEO has determined that additional medical personnel are needed in order to address the emergency, all as further described in the Credentials Policy Manual.

SECTION 3.11. CREDENTIALS POLICY MANUAL

Full details regarding the credentialing/re-credentialing, appointment/reappointment and privileging/re-privileging processes are set forth in the Credentials Policy Manual.

SECTION 3.12. FOCUSED PROFESSIONAL PRACTICE EVALUATION ("FPPE").

The Medical Staff has defined the circumstances requiring monitoring and evaluation of specific competencies of all practitioners granted Privileges in its OPPE/FPPE Plan, as well as in specific Department policies and procedures. Such monitoring may include but not be limited to: chart review, tracking volume and generic indicators, performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, direct observation, discussion with other healthcare individuals involved in the care of the patient, and prospective, concurrent, or retrospective proctoring. A period of FPPE defined by time or a specific number of cases is implemented by the Department Chair for all new Privileges granted by the Board either upon initial appointment or upon requests for additional Privileges.

SECTION 3.13. ONGOING PROFESSIONAL PRACTICE EVALUATION ("OPPE")

The Medical Staff will engage in ongoing professional practice evaluations on a regular basis[1] of all practitioners granted Privileges in order to improve and monitor current competencies. Through an ongoing review of performance measurements which are specifically set forth in its OPPE/FPPE Plan and in specific Department policies and procedures, negative trends are tracked and trended in a manner that allows the leadership to identify performance issues that affect quality of care and patient safety, and implement strategies that will effect change on a timely basis. Information from this evaluation process will be factored into the decision to allow practitioners to maintain, revise, suspend, or revoke existing Privilege(s) prior to or at the time of reappointment. In addition, each practitioner may be subject to FPPE when issues affecting the provision of safe, quality patient care are identified during the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific Privilege.

SECTION 3.14. HISTORY AND PHYSICAL

A medical history and physical examination must be completed and documented for each patient no more than 30 days before or within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. Exceptions to this requirement include emergent lifesaving procedures or imminent deliveries. The medical history and physical examination must be completed and documented by a physician, oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law, and who is credentialed and privileged in accordance with Hospital policy.

An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration; but, in all cases, prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law, and who is credentialed and privileged in accordance with Hospital policy. An Emergency Department evaluation may be accepted as a history and physical examination for purposes of emergency procedures provided that the entry documenting an examination is complete, including any changes in the patient's condition.

An osteopathic musculoskeletal examination is required as an integral part of the history and physical performed by osteopathic physicians unless contraindicated. The reason for omitting the musculoskeletal examination is documented in those cases where this examination is contraindicated.

The medical history and physical examination requires co-signatures in all circumstances when not completed by a Physician or other appropriately qualified and licensed individual as permitted by Clinical Privileges in compliance with then-current accreditation standards, federal and state

[1] The review is documented in the Credentials file by the Department or Section Chair (or designee) three times during the two-year appointment cycle (e.g. every 6 - 9 months) as determined by the Chair, but more often than every 12 months.

law, and Medical Staff/Hospital policies. Those practitioners who do not have Clinical Privileges to perform a full history and physical are responsible for the part of their patient's history and physical examination that relates to their specialty. A podiatrist who qualifies for membership and Privileges, or a NPP who qualifies for Privileges, may perform a history and physical examination within their legally authorized scope of practice as defined by Ohio law at the time of admission and in compliance with these Bylaws, Manuals, Policies, and the delineation of Privileges granted by the specific KHN Hospital where he/she practices.

See Organization and Functions Manual, Rules and Regulations for additional information regarding the History and Physical.

SECTION 3.15. ADMITTING PRIVILEGES FOR NPPs

Certain NPPs provide medical care under the supervision of a licensed physician as requested on their delineation of Privileges and granted through the credentialing process outlined in these Bylaws and the Credentials Policy Manual. In accordance with Ohio law (ORC 3727.06), a Clinical Nurse Specialist, a Certified Nurse Midwife, a Certified Nurse Practitioner and a Physician Assistant-Certified may admit patients to a hospital if certain conditions specified in ORC 3727.06 are met, including that a hospital must have implemented applicable privilege sets and computer systems processes to enable it to grant admitting privileges and appropriate credentials in accordance with such hospital's bylaws.[1] Applicable current laws, codes and/or regulations governing the scope of admitting practices for NPPs are available online and through the Medical Staff Services Department.

Details regarding the credentialing and privileging process for NPP admitting privileges are set forth in the Credentials Policy Manual.

SECTION 3.16. ORDERS FOR OUTPATIENT SERVICES

Orders for outpatient services (as well as patient referrals for hospital outpatient services) may be made by any practitioner who satisfies the Hospital's written policy for ordering certain or all types of outpatient services and for referring patients for such applicable Hospital outpatient services, so long as such policy has been authorized by the particular Hospital's Medical Staff, approved by the Board, and complies with applicable Medicare Conditions of Participation and accreditation standards requiring that any such practitioner must be:

- Responsible for the care of the patient;
- Licensed in, or holds a license recognized in the jurisdiction where he/she sees the patient; and
- Acting within his/her scope of practice under State law.

[1] The Medical Staff at each Hospital has the discretion to grant or not to grant such privileges to NPPs in compliance with the provisions of ORC 3727.06, these Bylaws, and the Crerdentials Policy Manual. The following Hospitals have complied with the provisions of ORC 3727.06 and certain of such NPPs have been appropriately credentialed at such Hospitals in accordance with these Bylaws and the Credentials Policy Manual and have been granted admitting privileges at only such Hospitals: FHH

Such policy may include both Practitioners who are on the Hospital Medical Staff and who hold Privileges that include ordering the services, as well as other practitioners who are unaffiliated with and/or are not on the Hospital Medical Staff, but who satisfy the particular Hospital's policies for ordering applicable outpatient services and for referring patients for Hospital outpatient services.

SECTION 3.17 IMMUNIZATIONS & HEALTH SCREENINGS

All Practitioners and NPPs shall comply with Hospital health screening and immunization requirements (or be granted an exemption thereto) set forth in applicable Hospital/Medical Staff policies.

ARTICLE 4.

CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Hospital Board in accordance with State law and these Bylaws, and shall be to one of the categories of the Medical Staff set forth in this Article. The Medical Staff is comprised of doctors of osteopathy and medicine, and, in accordance with State law, those other practitioners appointed by the Hospital Board.

Unless otherwise specified, in addition to the duties and responsibilities applicable to the Appointees of each particular category of the Medical Staff set forth in this Article, each Appointee shall:

(a) assume and carry out responsibility within the Appointee's area of professional competence for the continuous care and supervision of each patient in the Hospital for whom services are being provided;

(b) call for and respond to consultations when required by patient condition or Hospital requirement;

(c) participate in Medical Staff functions, committee activity, educational activities, and quality improvement activities as required by these Bylaws and the Rules and Regulations of the Hospital;

(d) abide by the code of Ethics of the American Osteopathic Association, the American Medical Association, or the code of ethics prescribed by the Appointee's profession;

(e) abide by these Bylaws and by all other standards, policies and Rules and Regulations of the Hospital and of the Clinical Departments and Sections of which the Appointee is a member;

(f) unless otherwise subject to Hospital contractual arrangements, each member of the Active and Courtesy Medical Staff shall (to the extent applicable) designate at least one appropriately qualified alternate staff member with the alternate's approval. A new designation will be completed upon reapplication for staff privileges every two (2) years or as often as is necessary. It is the physician and/or the designated alternate physician's responsibility to notify the Medical Staff Services Department or the office of the CMO of any change in the designated alternate. In the event the Member cannot be reached within a reasonable period of time to manage an urgent problem, the alternate may be called in his/her place. If neither the Member nor the alternate physician is available, the Chair of the appropriate Clinical Department or Section shall have the authority to call any Member of the Staff to manage the problem. Refusal to respond when called, without good cause, will result in disciplinary action.

(g) A Medical Staff Member may request a change in his/her status during the reapplication process. If such change is requested at any other time, the Member shall notify the Medical Staff Services Department, or the Chief of Staff, or the CMO, in writing, of the desired change in status. The requested change in status shall become effective upon approval by the appropriate Department and Section Chair, Medical Executive Committee, and the Hospital Board.

SECTION 4.1. ACTIVE AND EMERITUS-ACTIVE MEDICAL STAFF

4.1.1. Active Medical Staff

Appointment to the Active Medical Staff will be subject to the FPPE[1] for at least one (1) year pending satisfactory clinical performance and fulfillment of other Medical Staff requirements as determined by the Department/Section Chair, the Credentials Committee and the Medical Executive Committee, and as approved by the Board. Active Appointees consist of those Physicians, Dentists, Podiatrists, and Psychologists who engage in significant clinical practice at the Hospital. Hospital-based Practitioners (including but not limited to anesthesiologists, emergency medicine physicians, nuclear medicine physicians, pathologists, radiologists, and radiation oncologists) who are either employed by the Hospital or have exclusive contracts for the provision of patient care at the Hospital must meet the qualifications for Active Medical Staff.

4.1.1.1. Qualifications. Appointees to this category must:

(a) Meet all qualifications for Medical Staff appointment set forth herein.

(b) Actively participate in Medical Staff activities and responsibilities, such as committee and Clinical Department/Section assignments.

(c) Provide evidence of clinical performance at all other hospitals in which they other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Appointee's qualifications.

(d) Active Staff members shall have at least 50 patient encounters per year, but may admit and consult on additional patients without limitation, except as otherwise provided in these Bylaws or by specific privilege restriction; provided, however, dentists, psychologists and optometrists may only co-admit with a

[1] During this one year FPPE period, the Appointee shall be subject to close supervision and evaluation by the Chair of the Department to which he or she is assigned subject to the focused professional practice evaluation in which the privilege-specific competence of the Practitioner who does not have documented evidence of competently performing the requested privilege at the Hospital in the past is evaluated pursuant to service-specific criteria established by each Department and approved by the MEC. Such monitoring may use prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, tracking performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of patients. Such Appointees of any new Hospital who are subject to such FPPE may hold an elected position (e.g. an Officer or Chair position), and may serve on committees with vote.

Physician with admitting privileges. Podiatrists may admit and consult in accordance with such Podiatrist's individual Hospital Privileges.

4.1.1.2. Prerogatives. Appointees to this category may:

(a) Admit, treat and consult on patients without limitation, including ordering diagnostic or therapeutic services, in accordance with the Privileges granted, except as otherwise provided in the Medical Staff Rules & Regulations or by specific privilege restriction.

(b) Order outpatient invasive and noninvasive services in all KHN Hospitals in accordance with Hospital policy, or refer patients to other members of the Medical Staff.

(c) Attend meetings of the Medical Staff and of the Clinical Department/Section of which the Practitioner is member as well as Medical Staff or Hospital education programs.

(d) Vote on all matters presented at general and special meetings of the Medical Staff, and of the Clinical Department/Section and committee(s) of which the Practitioner is a member.

(e) Hold a Medical Staff office, serve as a Clinical Department/Section Chair, and sit on or be the Chair of any committee, unless otherwise specified in these Bylaws.

(f) Participate in Hospital and Medical Staff education programs as appropriate.

4.1.1.3. Responsibilities. Appointees to this category must:

(a) Contribute to the organization and administrative affairs of the Medical Staff.

(b) Actively participate in recognized functions of Medical Staff appointment, including performance improvement, peer review, and other monitoring activities; proctor Appointees during their provisional period or when new privileges are granted; and discharge other Medical Staff functions as may be required from time to time.

(c) Participate in the care of unassigned patients, Emergency Department Call, consultation and other specialty coverage programs, as requested by the Medical Staff, Administration or Board. Appointees with unique or scarce expertise are expected to collegially assist other Appointees when urgent patient care needs arise. This assistance is not intended to be unreasonably burdensome. Active Appointees

who advance to the Emeritus-Active Medical Staff category shall not be required to comply with this requirement.

(d) Attend meetings of the Staff, Department or Section and applicable committee meetings.

(e) Serve on Medical Staff committees, as assigned.

(f) Faithfully perform the duties of any office or position to which elected or appointed.

(g) Must pay all application fees, dues, and assessments that may be enacted by the Medical Executive Committee.

4.1.2. Emeritus-Active Medical Staff

An Appointee who is on the Active Medical Staff and who has attained the age of 65 years shall, on the Appointee's birth date, advance to the Emeritus-Active Staff. The Appointee shall be relieved of the payment of assessments and re-credentialing fees, and may participate in Medical Staff activities voluntarily accepted as assigned by the Chair of the Appointee's Clinical Department or Section, the CMO, or the Chief of Staff. Such advancement to this category will normally occur upon reappointment, but, as in the case of all persons appointed to the Active Medical Staff, may occur at any time during the appointment years if warranted. Persons appointed to the Emeritus-Active Staff shall be entitled to vote at Medical Staff Clinical Department and Section meetings and to hold Medical Staff offices.

SECTION 4.2. COURTESY MEDICAL STAFF

Appointment to the Courtesy Medical Staff will be subject to the FPPE[1] for at least one (1) year pending satisfactory clinical performance and fulfillment of other Medical Staff requirements as determined by the Credentials Committee and Medical Executive Committee, and approved by the Board.

4.2.1. Qualifications. Appointees to this category must:

(a) Meet all qualifications for Medical Staff appointment as set forth herein.

[1] During this one year FPPE period, the Appointee shall be subject to close supervision and evaluation by the Chair of the Department to which he or she is assigned subject to the focused professional practice evaluation in which the privilege-specific competence of the Practitioner who does not have documented evidence of competently performing the requested privilege at the Hospital in the past is evaluated pursuant to service-specific criteria established by each Department and approved by the MEC. Such monitoring may use prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, tracking performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of patients.

(b) Have not more than fifty (50) Patient Encounters in a consecutive twenty-four (24) month period (not including referrals to the Hospital's diagnostic facilities, access to which is unlimited). Appointees that have more than fifty (50) Patient Encounters may be considered for appointment to the Active Medical Staff.

(c) Provide evidence of clinical performance at all other hospitals in which they practice, in such form as the Hospital may reasonably request. In addition, they shall provide other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Appointee's qualifications.

(d) Provide consultations, and order diagnostic or therapeutic services, including outpatient services, in accordance with Hospital policy, or may refer patients to other members of the Medical Staff.

4.2.2. Prerogatives. Appointees to this category:

(a) May admit, treat, and consult on patients without limitation, based on applicable Privileges, except as otherwise provided in the Medical Staff Rules & Regulations, or by specific Privilege restriction.

(b) May order outpatient invasive and non-invasive services in all KHN Hospitals in accordance with Hospital policy, or refer patients to other members of the Medical Staff.

(c) May attend Medical Staff meetings (without vote).

(d) May attend applicable Clinical Department/Section meetings (without vote).

(e) May be invited to serve on committees (with vote).

(f) May not hold office or serve as a Clinical Department/Section Chair or committee Chair.

(g) Is excused from the care of unassigned patients and from Emergency Department Call (unless there is a determination by the applicable Clinical Department/Section Chair, Medical Executive Committee, Administration and/or the Board that Courtesy Medical Staff Appointees of a particular Clinical Department/Section must participate in these responsibilities).

(h) Must participate in performance improvement, monitoring, and peer review activities, including responding fully and timely to any inquiries regarding the care of patients.

(i) Must pay all application fees, dues and assessments, which may be enacted upon by the Medical Executive Committee.

4.2.3. Responsibilities.

Unless otherwise stated, Appointees to this category have the same responsibilities as Active Medical Staff, as requested.

SECTION 4.3. ASSOCIATE MEDICAL STAFF

4.3.1. Membership Only Professional

4.3.1.1. Qualifications. The Associate Medical Staff – Membership Only Professional staff shall consist of those practitioners who desire to be associated with the Hospital, but who do not intend to provide patient care at the Hospital, including community based physicians. The primary purpose of this category is to promote professional and educational opportunities, including continuing medical education endeavors, and to allow such practitioners to refer patients to other Appointees for admission, evaluation, and/or care and treatment. Appointees to this category must meet the general qualifications for appointment but shall not be required to maintain professional liability insurance or to otherwise provide documentation establishing current clinical competence.

As practitioners seeking or who have been granted Membership Only Professional status have no Clinical Privileges, they are not entitled to due process rights and/or formal hearings under these Bylaws. A practitioner who believes he or she was wrongly denied such status, or whose status was terminated, may submit information to the MEC demonstrating why the denial or termination was unwarranted. The MEC, in its sole discretion, shall decide whether to review the submission. The practitioner has no appeal or other rights in connection with the MEC's decision.

4.3.1.2. Prerogatives. Appointees to this category:

(a) May attend meetings of the Medical Staff and appropriate Clinical Department/Section (with vote).

(b) May not be granted Privileges and may not admit, or treat or consult on patients admitted as inpatients in the Hospital; but shall: (1) be eligible to vote on matters presented to the medical staff, (2) hold an elected office, and (3) serve on any committees (with vote).

(c) May attend educational programs of the Medical Staff.

(d) May refer patients to Appointees of the Active and Courtesy Medical Staff for admission and/or treatment, and may order diagnostic or therapeutic services, including outpatient invasive and non-invasive services, in accordance with Hospital policy.

(e) May visit their patients when hospitalized and review their medical records (provided the patient consents), but may not write orders, make medical record entries, or otherwise actively participate in the provision or management of care to Hospital inpatients.

(f) May refer patients to the Hospital's diagnostic and treatment facilities.

(g) May not be granted privileges and may not admit or treat patients at the Hospital.

4.3.1.3. .Responsibilities. Appointees to this category:

Must pay all application fees, dues and assessments that are enacted by the Medical Executive Committee.

4.3.2 Membership Only Honorary

4.3.2.1. Qualifications. The Associate Medical Staff – Membership Only Honorary staff shall consist of physicians, dentists, podiatrists and psychologists who do not actively practice at the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, and/or their previous longstanding service to the Hospital, and who continue to exemplify high standards of professional conduct. Requests for appointment to the Honorary Staff will be directed to the MEC and shall be a lifetime appointment.

4.3.2.2. Prerogatives. The Associate Medical Staff – Membership Only Honorary staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital, or to vote or hold office in the Medical Staff, but they may serve on committees with or without vote at the discretion of the MEC. They may attend staff and Department/Section meetings, including open committee meetings and educational programs.

4.3.2.3. Responsibilities. Appointees to this category shall have no responsibilities other than, if appointed to a committee, to act consistent with that committee's responsibilities (with or without vote at the discretion of the MEC).

4.3.3 Membership Only Retired

4.3.3.1. Qualifications. The Associate Medical Staff – Membership Only Retired staff shall consist of Practitioners who have retired from active practice and who, at the time of their retirement, were Appointees in good standing to the Medical Staff, and who continue to adhere to appropriate professional and ethical standards. They shall have no privileges and shall be exempt from all Medical Staff qualifications and requirements. Requests for appointment to the Retired Staff will be directed to the MEC and shall be a lifetime appointment.

4.3.3.2. Prerogatives. The Associate Medical Staff – Membership Only Retired staff:

(a) Shall not be eligible to have Privileges, to vote, to hold office, or to serve on standing Medical Staff Committees.

(b) May attend educational programs at the Hospital.

(c) May be requested to sit on an ad hoc committee of the Medical Staff. If so appointed, they may participate on such committee with vote.

4.3.3.3. Responsibilities. Appointees to this category shall have no responsibilities other than, if appointed to a committee, to act consistent with that committee's responsibilities (with vote).

4.3.4. Clinical Privileges Only

4.3.4.1. Qualifications. The Associate Medical Staff – Clinical Privileges Only staff shall consist of those Practitioners who desire to have clinical privileges with the Hospital, but who do not desire Medical Staff Membership. This category is limited to those Practitioners who desire to provide health care services to patients in either a locum tenens and/or proctoring capacity or residents who desire an opportunity to obtain privileges to moonlight in the Hospital. Appointees to this category must:

(a) Meet all qualifications for Medical Staff appointment as set forth in these Bylaws, with the exception of residents who will not have yet been able to fulfill all the eligibility criteria.

(b) Provide evidence of clinical performance at all other hospitals and healthcare organizations in which they practice, in such form as the Hospital may reasonable request. In addition, they shall provide other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Appointee's qualifications.

4.3.4.2. Prerogatives. Appointees to this category:

(a) Admit and consult on patients without limitation, except as otherwise provided in the Medical Staff Rules & Regulations or by specific privilege restriction.

(b) Participate in Hospital and Medical Staff education programs as appropriate.

(c) Have no Medical Staff committee responsibilities, but may be assigned to special committees (with vote on such special committees only).

(d) May refer patients to Appointees of the active and courtesy Medical Staff for admission and/or treatment, and may order diagnostic or therapeutic services, including invasive and non-invasive outpatient services, in accordance with Hospital policy.

(e) May not vote (except on assigned special committees) or hold office.

4.3.4.3. Responsibilities. Appointees to this category:

(a) Participate in the care of unassigned patients, Emergency Department Call, consultation and other specialty coverage programs, as requested by the Medical Staff, Administration or Board. Medical Staff members with unique or scarce expertise are expected to collegially assist other medical staff members when urgent patient care needs arise. This assistance is not intended to be unreasonably burdensome.

(b) Attend applicable meetings.

(c) Must pay all application fees, dues and assessments, which may be enacted upon by the Medical Executive Committee.

4.3.5. Telemedicine Privileges Only

4.3.5.1. Qualifications. The Associate Medical Staff – Telemedicine Privileges Only staff are providers who are not currently affiliated with the Hospital and provide clinical services pursuant to a telemedicine link. These providers are privileged either through routine privileging process or pursuant to the provisions of a written agreement with a distant-site Medicare-participating hospital or telemedicine entity which permits the Medical Staff to recommend, and the Board to grant, privileges based upon the privileging decision of the distant-site telemedicine hospital or entity. The telemedicine provider must meet the telemedicine credentialing and privileging qualifications as defined by the Medicare Conditions of Participation, Ohio law (non-Ohio physicians must hold a current, valid telemedicine certificate issued by the State Medical Board of Ohio), accreditation standards and Hospital Medical Staff Bylaws and policies as approved by the Board.

4.3.5.2. Prerogatives. Appointees to this category may:

(a) Provide telemedicine consultations.

(b) Participate in Hospital and Medical Staff education programs.

(c) May not vote or hold office.

4.3.5.3. Responsibilities.

Have no Medical Staff committee responsibilities, but may be assigned to special committees (with vote).

4.3.6. Consulting Medical Staff

4.3.6.1. Qualifications. The Consulting Staff shall consist of medical practitioners of recognized professional specialty abilities who are not applicants for Medical Staff membership

and are not members of another category of the Medical Staff and may be granted limited privileges for the specific purpose of providing consultation in the diagnosis and treatment of patients. Consulting Staff shall be certified or eligible for certification by their respective specialty boards, or by others whom the Medical Executive Committee, after receiving the recommendation of the Credentials Committee and appropriate Clinical Departments or Sections, considers worthy of appointment to this category of the Medical Staff.

4.3.6.2. Prerogatives. Appointment to the Consulting Staff does not entitle the Appointee to admit patients, or to vote at meetings of the Medical Staff or at meetings of the Clinical Department and Section meetings, or to hold Medical Staff offices. Appointees may order diagnostic or therapeutic services, including outpatient services in accordance with Hospital policy, or may refer patients to other members of the Medical Staff. Appointees may exercise only those privileges granted to them for the specific purpose(s) requested.

4.3.6.3. Responsibilities. Unless otherwise stated, Appointees to this category shall have no responsibilities other than, if appointed to a committee, to act consistent with that committee's responsibilities (with or without vote at the discretion of the MEC); and to comply with all applicable provisions of these Bylaws and with Hospital policies and procedures while consulting in regards to Hospital patients. Such Appointees need not attend Medical Staff meetings.

SECTION 4.4. DENTISTS, PODIATRISTS, PSYCHOLOGISTS AND OPTOMETRISTS

4.4.1. Dentists and Psychologists who are admitted to the Medical Staff may admit patients with osteopathic physicians or medical physicians who are members of the Medical Staff and who will manage the medical care required by the patient which is not within the scope of such Practitioner's licensure or Clinical Privileges.

4.4.2. Podiatrists who are appointed to the Medical Staff may admit, write orders, perform a history and physical examination, and manage their patients in compliance with their legally authorized scope of practice as defined by Ohio law at the time of admission, and in accordance with the Bylaws, Manuals, Policies and the delineation of Privileges granted by the specific KHN Hospital where he/she practices. Where a Podiatrist admits a patient having concomitant medical problems, or where such medical problems arise during the hospitalization, such Podiatrist shall promptly engage an attending Physician who shall have responsibility for any medical treatment that may be appropriate during such patient's hospitalization. If the KHN Hospital where the Podiatrist practices does not permit Podiatrists to perform a history and physical examination, then such Podiatrist may only co-admit with a Physician having Hospital admitting privileges who shall be medically responsible for that patient's non-podiatric care during the hospitalization; and who must review and co-sign the history and physical examination performed by the Podiatrist.

4.4.3. Licensed optometrists who hold a current Therapeutic Pharmaceutical Agents Certificate may prescribe and dispense as defined by the Ohio State Board of

Optometry and as set forth in Ohio law. A Staff physician will perform a general medical examination and assume overall medical management of the patient.

SECTION 4.5. PROBATIONARY MEDICAL STAFF STATUS

The MEC may impose a probationary Medical Staff status for corrective action issues related to privileges and/or for non-clinical reasons. Probation is not punitive in nature, is not an adverse reflection of the Appointee's skills or character, and does not constitute an adverse action, as defined. Probation is imposed when more specific, first-hand observation is needed to evaluate a Practitioner. Probation imposed for a problem in professional conduct acts as a letter of warning and is not an adverse action, but serves as notice that certain conduct will not be tolerated and that a repeat occurrence will result in a request for corrective action. The MEC shall define the time period (not longer than one (1) year) and the expected requirements of a successful probationary period. If the Appointee does not successfully fulfill the requirements of the probationary period as determined by the MEC, then the MEC may initiate corrective action in accordance with these Bylaws.

SECTION 4.6. RESIDENTS AND FELLOWS

Residents and fellows in training will act under the auspices of their approved and accredited program of graduate medical education in carrying out clinical care in accordance with written educational protocols delineating the roles, responsibilities, and scope of clinical activities applicable to such trainees. Residents and fellows are not members of the Medical Staff, do not have specific Privileges, and shall not be entitled to any of the rights granted under these Bylaws, including but not limited to hearing and appeal rights. Residents and Fellows who moonlight outside of their graduate medical education program shall do so pursuant to Subsection 4.3.4.1 hereunder.

ARTICLE 5.

OFFICERS OF THE MEDICAL STAFF

SECTION 5.1. OFFICERS OF THE MEDICAL STAFF

5.1.1. The officers of the Medical Staff shall be:

- Chief of Staff
- Vice Chief of Staff
- Immediate Past Chief of Staff
- Secretary/Treasurer[1]
- Other such officers as may be authorized by a vote of the Appointees to the active Medical Staff

SECTION 5.2. QUALIFICATION OF OFFICERS

5.2.1. Officers must:

(a) Be current Appointees to the Active Medical Staff.

(b) Have been on the active Medical Staff for at least the previous three (3) consecutive years, or have MEC approval[2].

(c) Be in Good Standing at the time of nomination and election.

(d) Remain active Appointees in Good Standing during their term(s) of office.

(e) Be currently board certified (i.e. having maintained at least one current board certification) as specified by the ABMS, AOA, ABOMS, ABPS or ABPPMO).

(f) Have experience in a Medical Staff leadership position or equivalent (e.g., have served as a Department or committee chair or as a member of the MEC).

(g) Have received Medical Staff leadership training or demonstrate a willingness to attend such training as required for the position.

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[1] The function/duties of this office, as deemed necessary, may be performed by such other officers/positions as designated by an individual Hospital's Medical Staff, except that such function/duties may not be included in the duties of the Chief of Staff.

[2] When a new hospital adopts and effectuates these Bylaws in accordance with Section 13.6 of Article 13, the consecutive three (3) year requirement is waived through a future date corresponding to the number of required years of active Medical Staff appointment. Thereafter, the requirement as set forth in the Bylaws shall be followed.

(h) Recognize and agree to the commitment of time needed to perform the duties associated with the role, and assume responsibility for participating in continued leadership education.

(i) Demonstrate the ability to communicate in a professional manner with colleagues, Hospital administration, and the Board, as relevant; and, at GV, must demonstrate a commitment to osteopathic practices and principles.

Individuals holding the offices of Chief of Staff and Vice Chief of Staff must be osteopathic or medical physicians.

Officers may not simultaneously hold leadership or board positions at another hospital other than such position at a KHN Hospital. In order to avoid a conflicting interest, any Appointee who is employed or whose practice is owned/managed/operated by a competing hospital/healthcare entity (as determined by the Board) is not eligible for Medical Staff leadership or Board positions, either elected or appointed, and is obligated to disclose such conflicting interests prior to accepting a Medical Staff officer position.

SECTION 5.3. ELECTION OF OFFICERS

5.3.1. General. Officers shall be elected bi-annually at a meeting of the Medical Staff. Unless otherwise stated in these Bylaws, only active Appointees shall be eligible to vote. Upon completion of the Chief of Staff term, the Vice Chief of Staff automatically becomes Chief of Staff.

5.3.2. Nominating Committee. The nominating committee shall be appointed by the MEC and shall consist of the Chief of Staff, the Vice Chief of Staff, two (2) other members of the Medical Executive Committee, two (2) other active Appointees who are not then members of the MEC.[1] The nominating committee will present a panel of candidates to the MEC for approval no later than two (2) months prior to the meeting at which the election shall be held. When approved, the names of the nominees will be distributed to all active Appointees.

5.3.3. Additional Nominations. Within thirty (30) days of distribution, additional nominations may also be made by petition signed by either five percent (5 %) of active Appointees or fifty (50) active Appointees, whichever is less. Such petition must be submitted to the Chief of Staff who shall then include these nominations on the distributed ballot.

5.3.4. Ballots. Ballots will be provided to active Appointees no later than thirty (30) days prior to the annual meeting. Ballots must be received by the Medical Staff Office no later than seven (7) business days prior to the meeting at which the election is to be held.

5.3.5. Disclosure of Conflicts. All nominees for election or appointment to Medical Staff offices at the time of nomination shall disclose in writing to the MEC those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf

[1] At GV, additional members are the Chairs of Internal Medicine, Surgery and Family Medicine.

of the Medical Staff. Such disclosures will be provided with the ballot. Such disclosures will not act as an automatic disqualification for such office.

SECTION 5.4. TERM OF OFFICE

All elected officers identified in this Article 5 will serve a term of two (2) years. Such Officers shall take office on the first day of the calendar year.[1] The number of consecutive terms such officer may serve in such position shall be limited to three (3) at the discretion of the nominating committee.

SECTION 5.5. VACANCIES IN OFFICE

Vacancies in office during the Medical Staff year, except the office of the Chief of Staff, shall be filled by the MEC. If there is a vacancy in the office of the Chief of Staff, then the Vice Chief of Staff shall serve the remainder of the term, and then may serve his/her own term as Chief of Staff. In such event, a new Vice Chief of Staff shall be elected by the voting Staff at the next Staff meeting to fill the unexpired term of his/her predecessor in office. If the Vice Chief of Staff is unable to succeed to this office, a special election will be held at the next Staff meeting or at a special meeting called for this purpose. Nominations shall be received from the floor and the election may be conducted by secret ballot. Such ballots are tallied by the Manager of the Medical Staff Services Department with results communicated to the Chair of the MEC. Vacancies in the offices of other Officers of the Medical Staff shall be filled in like manner.

SECTION 5.6. DUTIES OF OFFICERS

5.6.1. Chief of Staff. The purpose of this position is to provide overall leadership and guidance to the Medical Staff. The Chief of Staff is the chief executive officer of the Professional Staff and is a member of the Medical Executive Committee. The Chief of Staff promotes effective communications among the Medical Staff, Medical Executive Committee, Administration, and the Board. The Chief of Staff is, in general, responsible for Bylaws implementation, Medical Staff involvement in securing and maintaining Hospital accreditation, the provision of information to the Board concerning matters that pertain to the quality of care and treatment of patients, and facilitating positive relationships among administration, the Medical Staff, and other support services of the Hospital. The Chief of Staff is responsible for the organization and conduct of the Medical Staff, and is the individual (or designee), with whom the Board or its subcommittee meets with periodically throughout the calendar year (but at least twice per such year) in a manner that permits immediate synchronous communication to discuss matters related to the quality of medical care provided to Hospital patients. The Chief of Staff reviews and approves clinical policies and procedures as needed, but at least every three years, or as otherwise required by State regulations, Hospital or Medical Staff policy, and/or accreditation standards. The Chief of Staff and/or any designee assigned by the Chief of Staff may attend any committee or Department/Section meetings of the Medical Staff.

[1] The officers of new hospitals that adopt and effectuate these Bylaws in accordance with Section 13.6 of Article 13 shall take office upon election and serve the remaining months of such calendar year as year 1 of the term.

5.6.2. Vice Chief of Staff.. The purpose of this position is to provide continuity in leadership during times when the Chief of Staff is absent or otherwise unable to perform his/her assigned functions. In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. The Vice Chief of Staff will be expected to remain knowledgeable about all Medical Staff issues of current Medical Staff interest. At the conclusion of the term of the Chief of Staff, the Vice Chief of Staff will succeed as Chief of Staff.

5.6.3. Immediate Past Chief of Staff. The purpose of this position is to perform duties as shall be assigned by the Chief of Staff, the MEC, and/or the Board.

5.6.4. Secretary/Treasurer. The purpose of this office, as applicable, is (with the assistance of administrative support personnel), to give proper notice of all Medical Staff meetings; record or cause to be recorded complete and accurate minutes of all general meetings of the Medical Staff and the MEC; oversee collection of annual dues and the keeping of accurate accounts of Medical Staff funds, where applicable; oversee payment of the financial obligations of the Medical Staff, if any, after approval of the MEC or as directed by Medical Staff Policy; see that the books of the Medical Staff are submitted as/when necessary for accounting review and/or audit as directed by the MEC; and perform other duties as may be assigned by the Chief of Staff. As/when necessary, the Secretary/Treasurer will assume the duties and responsibilities of the Chief of Staff during the simultaneous temporary absence/unavailability of the Chief of Staff and the Vice Chief of Staff until such absence/unavailability is ended.

Refer to the Organization and Functions Manual for additional details as to the position requirements, accountabilities and functions of the officers of the Medical Staff.

SECTION 5.7. REMOVAL FROM OFFICE

Any officer of the Medical Staff identified in this Article 5 may resign at any time by giving written notice to the Medical Executive Committee. Such resignation shall take effect on the date of receipt or at any later time specified therein.

Removal of an officer during his/her term of office will be immediate upon loss of licensure, loss of clinical privileges at the Hospital, or failure to remain an active Appointee in Good Standing.

Any officer of the Medical Staff may be removed from office for conduct detrimental to the interests of the Medical Staff (malfeasance in office) or for failure to fulfill the duties of the office. A request for the removal of any officer must be made in writing by the Board, the MEC, or twenty-five percent (25%) of the active Appointees and delivered to the Medical Staff Services Department. The request for removal shall state the basis for the request and shall be signed by an appropriate member of the Board, the MEC or a petition signed by each of the Medical Staff members requesting the removal. The Medical Staff Services Department shall deliver a copy of the written request to the officer. Within thirty (30) days of receiving said request, a special meeting of the active Medical Staff is held where the affected officer may present his/her position for remaining in office. The Medical Staff shall vote by a written ballot. No officer shall be removed from office without a two-thirds vote of active Appointees in favor of removal, subject

to ratification by the MEC and the Board. Removal does not affect an officer's privileges and does not afford due process rights under these Bylaws.

ARTICLE 6.

ORGANIZATION OF THE MEDICAL STAFF

The Medical Staff, acting through its Departments, Sections and committees provides a mechanism and assumes accountability to the Board for the quality and appropriateness of patient care, as well as the conduct of Appointees, privileged Practitioners, and APPs. The Medical Staff, acting through its Departments, Sections and committees provides education, including undergraduate and postgraduate education; conducts or coordinates quality and utilization review activities throughout all levels of the organization; initiates and enforces Bylaws and policies (as approved by Board for self-governance of Medical Staff); reviews and evaluates the performance of Privileges granted on a continuing basis; acts on reports of its Departments, Sections and committees and provides reports to the Board regarding Medical Staff matters; and discharges duties and responsibilities delegated to it by the Board to make recommendations regarding appointment, reappointment, Privileges, and actions necessary in connection with Appointees. The Medical Executive Committee shall constitute the governing body of the Medical Staff as described in these Bylaws.

SECTION 6.1. Staff Year

For the purpose of these Bylaws, the staff year commences on the first day of January and ends on the 31st day of December each year. All persons appointed to the Medical Staff shall pay such assessments as may be established by the Staff.

SECTION 6.2. Officers of the Medical Staff

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, and the Secretary/Treasurer. The positions, requirements, accountabilities and functions, and terms of the Medical Staff officers are described in general in these Bylaws (*see* Article 5), and in further detail in the Organization and Functions Manual.

SECTION 6.3. Meetings of the Medical Staff

6.3.1. Annual Meeting.

The voting Staff of the Hospital shall meet once a year at such time as the Chief of Staff shall determine, hold a meeting at which officers and members at large of the MEC for the ensuing term shall be elected from a slate provided by the Nominating Committee. At this meeting, the retiring officers and committees shall make such reports as may be indicated.

6.3.2. Regular Staff Meetings.

The Staff shall meet at least three (3) times a year at such date and times as determined by the Chief of Staff with notice provided to the Staff in early December prior to the beginning of each year, for the purpose of reviewing and evaluating Clinical Department, Section and committee reports and acting on any other matters placed on the agenda by the Chief of

Staff, and such meetings shall be governed by the most recent edition of Roberts Rules of Order.

6.3.3. Special Staff Meetings.

Special meetings of the Medical Staff may be called at any time by the Board, the President, the Chief of Staff, a majority of the MEC, or a petition signed by not less than one-fourth (1/4th) of the Active Staff. In the event that it is necessary for the Staff to act on a question without being able to meet, the Active Staff may be presented with the question by regular mail or electronic transmissions, and their votes returned to the Chief of Staff by regular mail or electronic transmissions by the date/time indicated; and such a vote shall be binding so long as the question is voted on by the due date by a quorum of the Staff eligible to vote.

6.3.4. Notice of Special Meeting.

A written notice stating the place, day, hour and purpose of any special meeting of the Staff shall be sent to each Appointee eligible to vote not less than seven (7) business days before the date of such meeting via regular mail or a commercially reasonable means of receipted delivery, including electronic transmissions, all as sent to the address/number provided by the Appointee as it appears on the records of the Hospital. Notice of an urgent meeting to be held in less than seven (7) business days' time must be given within 24 hours prior to the meeting time by telephone or a commercially reasonable means of receipted delivery, including electronic transmission. The notice of the meeting shall be deemed delivered when deposited in the United States mail or upon confirmation of the recipient either orally (documented) or via an electronic transmission. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

6.3.5. Quorum. For Annual or Special Meetings, the presence of five percent (5%) of the voting members shall constitute a quorum for all actions. For Regularly scheduled Meetings, fifty-one percent (51%) of those in attendance shall constitute a quorum for all actions. This quorum must exist for any valid action to be taken.

6.3.6. Agenda

6.3.6.1. Regular Meetings. The agenda at any regular Staff meeting shall be at the discretion of the Chief of Staff and, in general may include:

(1) Call to order

(2) Acceptance of the minutes of the last regular and of all intervening special meetings

(3) Report of the Medical Executive Committee

(4) Committee reports

(5) Discussion and recommendations for improvement of the professional work of the Hospital

(6) Old business

(7) New business

(8) Adjournment

6.3.6.2. Special Meetings. The Agenda for any special meeting shall be:

(1) Reference to the notice calling the meeting

(2) Transactions of business for which the meeting was called

(3) Adjournment

SECTION 6.4. Clinical Department, Section and Committee Meetings

6.4.1. Clinical Department and Section Meetings. Members of each Clinical Department or Section shall meet as a Clinical Department or Section at a date and time set by the Chair to review and evaluate the clinical work of the Clinical Department or Section and to discuss any other matters concerning the Clinical Department or Section. The agenda for the meeting and its general conduct shall be set by the Chair. The agenda shall generally contain business, educational and clinical quality portions. The Chief of Staff may attend any Clinical Department or Section meetings.

6.4.2. Committee Meetings. The time, place and agenda for the meeting and its general conduct shall be set by the Chair.

6.4.3. Special Clinical Department, Section and Committee Meetings. A special meeting of any Clinical Department, Section or committee may be called by or at the request of the Chair, by the Chief of Staff, by the CMO or by a petition signed by not less than one-fourth (1/4th) of the members of the Clinical Department, Section or committee. Written (including facsimile or electronic transmission) or documented oral notice stating the place, day and hour of any special or regular meeting shall be given to each member of the Clinical Department, Section or committee not less than seven (7) business days before the time of such meeting (unless an urgent meeting is called, then notice must be given by documented oral (including) telephone, or electronic transmission within 24 hours prior to the meeting time) with all being sent to the address/number provided by the Appointee as it appears on the records of the Hospital.

The written notice of the special meeting shall be deemed delivered when deposited in the United States mail or upon confirmation of an electronic transmission or when given orally. No business shall be transacted at any special meeting except that stated in the notice calling the meeting. The attendance of any member at a meeting shall constitute a waiver of the individual's notice of such meeting, meaning that if a member attends a meeting, s/he cannot later state any type of objection to the meeting or its actions based on not having received proper notice of the meeting.

In the event that it is necessary for a Clinical Department, Section or committee to act on a question without being able to meet, the voting members may be presented with the question in person, or by facsimile, or by regular mail or electronic transmission; and their vote returned to the Chair of the Clinical Department, Section or committee in similar fashion. Such a vote shall be binding so long as the question is voted on by the due date by a majority of the Clinical Department, Section or committee eligible to vote.

6.4.4. Quorum. The presence of 51% of voting members in attendance at any regular or special Clinical Department or Section or committee meeting shall constitute a quorum for all actions.

6.4.5. Minutes. Minutes of each meeting of each Clinical Department or Section shall be prepared by an administrative support person and shall include a record of the attendance of members, the recommendations made, and the votes taken on significant matters. The minutes shall be signed by the presiding officer and copies thereof shall be promptly forwarded to the MEC and at the same time to the Hospital President and the CMO and shall be stored per policy of the Medical Staff Services Department.

SECTION 6.5. Provisions Common To All Meetings

6.5.1. Notice and Frequency of Meetings. Except other specified, written notice of all meetings of the Medical Staff, Clinical Departments, Sections and committees shall be sent to each Appointee to the Medical Staff or member of the applicable Clinical Department, Section or committee at least seven (7) business days in advance of such meetings. Such notice may be sent by regular mail or by electronic transmission to the current electronic address(es) on file as provided by the Appointee. All committees, the MEC, Clinical and Standing Committees will meet yearly or more frequently as determined by the Committee Chair or as otherwise stated in these Bylaws and its governing manuals. Notice of an urgent meeting to be held in less than seven (7) business days' time must be given by telephone or electronic transmission within 24 hours prior to the meeting time. If a member personally attends a meeting, s/he cannot say that s/he did not receive notice of such meeting in order that his/her attendance cannot be counted or to argue that the meeting did not have a quorum; unless such person attends a meeting for the express purpose of objecting at the beginning of the meeting, to the transaction of any business at such meeting on the basis that the meeting was not duly called or convened.

6.5.2. Attendance Requirements. Staff membership, with resulting privileging, carries obligations to reasonably participate in Medical Staff self governance. Each Appointee to the Active Staff is expected to attend all regularly scheduled Staff meetings and applicable Clinical Department, Section and committee meetings in each two-year reappointment cycle. Meeting attendance is considered as one parameter in the recredentialing process. The failure of any person required to meet the foregoing annual Staff meeting and other attendance requirements shall constitute possible probation or resignation from the Staff pending the MEC and Board review. Reinstatement of an appointment which has been revoked because of absence from the required number of Staff meetings shall be made only upon reapplication, and all such applications shall be processed in the same manner as applications for initial appointment. Appointees to the Courtesy Staff category are

expected to attend and participate in meetings, but such attendance is not a condition of continued Staff appointment.

Any person appointed to the Medical Staff whose clinical work is scheduled for discussion at a regular Clinical Department, Section or committee meeting, and who is expected to attend such meeting shall be given advance written Special Notice of the time and place of the meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the individual shall so state, shall be given by Special Notice, and his/her attendance at the meeting at which the alleged deviation is to be discussed shall be mandatory.

The Chair of the applicable Clinical Department, Section or committee shall notify the Medical Executive Committee of the failure of an individual to attend any meeting with respect to which s/he was given notice that attendance was mandatory, and unless excused by the MEC upon showing of good cause, such failure shall result in an automatic suspension of all or such portion of the individual's admitting privileges as the MEC may direct and such suspension shall remain in effect until the matter is resolved. In all other cases, if the individual shall make a timely request for postponement supported by adequate showing that his/her absence will be unavoidable, the presentation may be postponed by the Chair of his/her Clinical Department or Section, or by the MEC until not later than the next regularly scheduled meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

Persons appointed to the Courtesy category of the Staff shall be expected to attend and participate in Clinical Department or Section meetings, but shall not be required to do so as a condition of continued Staff appointment.

6.5.3. Minutes. Minutes of all meetings, except as noted in the Bylaws, shall be prepared and include a record of attendance and the vote taken on each matter. Minutes are to be signed by the presiding chair or officer, forwarded to the MEC (or the parent committee in the case of a subcommittee), and presented to the attendees at a subsequent meeting for acceptance. Minutes shall be made available, upon request to and at the discretion of the Chief of Staff, to any Appointee who functions in an official capacity within the Hospital and has a legitimate interest in them. When access is approved, it shall be afforded in a manner consistent with the confidentiality policies of the Hospital concerning Medical Staff minutes and activities. A permanent file of the minutes of each meeting shall be maintained.

6.5.4. Rules of Order. The currently revised Roberts Rules of Order shall govern all meetings.

6.5.5. Voting. Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote. Unless otherwise specified in these Bylaws or governing manuals, voting may occur in any of the following ways as determined by the chair of the respective meeting or, for voting by the Medical Staff, as determined by the Chief of Staff:

(a) By hand, voice or written ballot at a meeting at which a quorum is present.

(b) By other technologically reasonable means of balloting (as determined by the Chair) at a meeting at which a quorum is present.

(c) Without a meeting, by written, electronic or facsimile ballot provided such ballots are received prior to the deadline date set forth in the notice advising of the purpose for which the vote is to be taken.

(d) Absentee written, electronic or facsimile ballot, provided the ballots are received prior to the deadline set forth in the notice advising of the purpose for which a vote is to be taken.

Unless otherwise specified in the Bylaws or governing manuals, Practitioners may participate in and act at any meeting by conference call or other communication equipment through which all persons participating in the meeting can communicate with each other. Participation by such means shall constitute attendance and presence in person at the meeting.

ARTICLE 7.

ORGANIZATION OF CLINICAL DEPARTMENTS AND SECTIONS

SECTION 7.1. ORGANIZATION OF CLINICAL DEPARTMENTS AND SECTIONS

7.1.1. Clinical Departments and Sections.

The Medical Staff is organized as a departmentalized Medical Staff with certain departments being comprised of specialty sections as outlined in the "List of Departments and Sections." Each Department or Section shall have a Chair whose functions are described in this Article. Each member of the Medical Staff who holds clinical Privileges shall be a member of a Department. A clinical Department is defined as all Medical Staff members at the Hospital who practice the same specialty or subspecialty, choose to be identified as a Department, fulfill the responsibilities of a Department, and are designated a Department by the Board, after consultation with the MEC, provided that a minimum of three (3) such active Appointees who practice at a single Hospital is required to constitute a Department. Those specialty or subspecialty areas not meeting all of these criteria may be organized as specialty Sections within a Department, with the approval of the Board after consulting with the MEC, so long as there are no fewer than three active Appointees per separate Section. Additional Departments or Sections may be established or eliminated if inactive by action of the Board after consultation with the MEC. Any such changes shall be reflected on the "List of Departments and Sections." Each Department or Section shall have a Chair whose functions are described in this Article. ***A current List of Departments and Sections is available in the Medical Staff Services Department.***

7.1.2. Functions of Clinical Departments or Sections.

Each Clinical Department or Section shall establish its own written criteria for the assignment of Clinical Privileges. Such criteria shall be consistent with these Bylaws and the policies of the Professional Staff and of the Hospital Board. Clinical Privileges shall be based upon demonstrated training and experience within the field covered by the Clinical Department or Section and upon standards reasonably related to accepted measures of skill, education, judgment, and competence.

Each Clinical Department or Section shall evaluate medical care on a retrospective basis and shall select cases for presentation at Clinical Department or Section meetings that will contribute to the continuing education of the members of the Clinical Department or Section. Such presentation shall include cases involving deaths or complications, and such other cases as are believed to be important, such as those involving patients currently in the Hospital with unsolved clinical problems.

Each Clinical Department or Section shall review all deaths of Clinical Department or Section physicians occurring in the Hospital. Such patient records shall be reviewed:

(a) to determine whether all cases had appropriate evaluation and care;

(b) to evaluate whether the attending physician was aware of the critical nature of the care as noted in the physician's orders, laboratory procedures orders, and timeliness of consultation orders;

(c) to examine the supervision of mortalities beginning with early recognition of complications, re-evaluation based upon clinical and laboratory studies, and modification of therapeutic regime in accordance with the changing condition of the patient to determine if the diagnosis can be supported; and

(d) to report educationally interesting cases to the appropriate committee for potential instructional use of the attending physicians and housestaff.

Each Clinical Department or Section shall cooperate with the Quality Assessment and Performance Improvement, Utilization Review and Credentials Committees and shall review and analyze on a peer-group basis the clinical work of the Clinical Department or Section. In discharging these functions each Clinical Department or Section shall report to the Quality Assessment and Performance Improvement and Utilization Review Committee detailing its analysis of patient care, and to the Credentials Committee whenever further investigation and appropriate action involving any individual member of the Clinical Department or Section is indicated.

7.1.3. Clinical Department or Section Officers

7.1.3.1. Organization.

Organized Clinical Departments must elect a Clinical Department Chair and a Clinical Department Vice Chair[1], each to serve for a two (2) year term (which may be repeated for an unlimited number of terms)[2]. Should the Department be unable to elect a Chair or Vice Chair, then the MEC will appoint a qualified Appointee to fill the vacant position.

7.1.3.2. Election Process[3]

(a) The Clinical Department Chairs will be elected by majority vote of the active Members of the Department participating in the vote.

(b) At least two (2) months prior to completion of the term of the Chair, the current Chair will issue a communication (i.e. memo, email, agenda item, etc.) calling for nominations.

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[1] The Vice Chair position is optional at the discretion of the Clinical Department or Section.
[2] At FHH, the Chair serves no more than 3 consecutive terms, unless otherwise approved by the MEC.
[3] At GV, the Chair of each Clinical Department shall be appointed by the Hospital Board after considering the recommendations of the members of the Clinical Department transmitted through the CMO; and the Vice Chair is appointed by the Board after receiving the recommendation of the Chair.
At FHH, the Chairs are elected or appointed subject to ratification by the MEC.

(c) 30 days prior to the next scheduled Department meeting, a ballot will be distributed to all active Appointees within the Department for vote.

(d) The results of the election will be announced at the next Department meeting.

7.1.3.3. Removal Process for Chair and Vice Chair[1]

Clinical Department Chairs/Vice Chairs may resign at any time by giving written notice to the MEC. Such resignation shall take effect on the date of receipt, or at such later time as specified in the written notice. Such may also be removed from their position by the MEC upon receipt of a recommendation of the majority of the active Appointees of the Department, or, in the absence of such recommendation, the MEC may remove such Chair on its own by a majority vote, of members present, if any of the following occurs:

- The Chair/Vice Chair ceases to be an active member in good standing of the Medical Staff or to otherwise meet the qualifications for the position (i.e. failure to maintain board certification).
- The Chair/Vice Chair suffers an involuntary loss or significant limitation of practice privileges.
- The Chair/Vice Chair fails, in the opinion of the MEC, to demonstrate to the satisfaction of the MEC or Board that he or she is effectively carrying out the responsibilities of the position.

If removal and/or vacancy of the Department Chair is required, then the Vice Chair automatically assumes the responsibilities of the Chair until a new election can be held or an appointment made by the MEC. If removal and/or vacancy of the Vice Chair occurs, then a new election can be held or an appointment be made by the MEC.

7.1.3.4. Chair

The Chair of each Clinical Department or Section shall be a physician member of the Active Staff who is qualified by training, practical experience in the specific area of medicine of the Clinical Department or Section, and administrative ability for the position. The Chair must have been an active Appointee for at least the

[1] At GV, a Chair/Vice Chair may resign in writing. Removal of a Chair/Vice Chair during his/her term of office may be initiated by a two-thirds (2/3rds) vote of all voting members of the Clinical Department or Section. This removal shall be effective when it has been approved by the Board.
At FHH, the Chair may resign in writing. Removal from office may occur at any time for gross neglect of duties, failing to represent the Department's interests, misfeasance in office or other appropriate condition upon two-thirds vote of the Department members eligible to vote on Departmental matters.
[2] When a new hospital adopts and effectuates these Bylaws in accordance with Section 13.6 of Article 13, the consecutive three (3) year requirement is waived through a future date corresponding to the number of required years of active Medical Staff appointment. Thereafter, the requirement as set forth in the Bylaws shall be followed.

prior 3 consecutive years[2]. The Chair must be certified by the appropriate certifying board.

Each Chair shall:

(a) be responsible for the organization of all Professional Staff activities of the Clinical Department or Section and for the general professional administration of the Clinical Department or Section;

(b) attend meetings of the Medical Executive Committee, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding the Clinical Department or Section in order to assure a high quality of patient care;

(c) review the professional performance of all individuals with Clinical Privileges in the Clinical Department or Section and report and recommend thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;

(d) be responsible for enforcement within the Clinical Department or Section of the Hospital bylaws and of the Professional Staff Bylaws, Rules and Regulations;

(e) be responsible for implementation within the Clinical Department or Section of actions taken by the Hospital Board and the MEC;

(f) transmit to the Credentials Committee the recommendations concerning the appointment, reappointment and delineation of Clinical Privileges for all individuals in and applicants to the Clinical Department or Section;

(g) be responsible for the establishment, implementation and effectiveness of the teaching, education and any research program in the Clinical Department or Section;[1]

(h) be responsible for the general administration of the Clinical Department or Section, reporting and recommending to Hospital administration when necessary with respect to matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;

(i) assist the Hospital administration in the preparation of annual reports and such budget planning pertaining to the Clinical Department or Section as may be required by the CMO, the Hospital President or the Hospital Board;

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[1] At GV, the Chair is also responsible for supervising and participating in osteopathic residency training, and for meeting the qualifications of the osteopathic resident director where applicable to the Department or Section, with waivers granted by the MEC upon good cause shown.

(j) assign such duties to a Vice Chair of the Clinical Department or Section as may be appropriate; and

(k) establish new Sections within the Clinical Department subject to the approval of the Medical Executive Committee and the Hospital Board, and appoint a chair for such Section who shall have such authority over specialty specific matters as they relate to the responsibilities of the Chair after consultation with the Chair.

(l) Review clinical policies and procedures of the Department or Section as needed, but at least triennially, to effectuate updates that reflect required changes consistent with current practice, problem resolution and standards changes, and provide such updates to the Chief of Staff.

7.1.3.5. Vice Chair[1] Each Vice Chair shall:

(a) have the same qualifications as the Chair of the Clinical Department or Section. The tenure of each Vice Chair shall coincide with that of his/her Chair.

(b) fulfill the duties of the Department Chair in the Chair's absence and carry out such other duties as may from time to time be reasonably requested by the Department Chair.[2]

[1] This position is optional at the discretion of the Clinical Department or Section.
[2] At GV, the Vice Chair also works with the Department Chair regarding all clinically related activities of the Department, chairs the Department's committee responsible for quality assessment and performance improvement activities, and also carries out duties as requested by the CEO, the Chief of Staff, the CMO, the MEC or the Board.

ARTICLE 8.

COMMITTEES OF THE PROFESSIONAL STAFF

There will be a Medical Executive Committee (MEC) and also the following required Hospital committees[1]: Utilization Review Committee and such other committees as may be required from time to time by accreditation standards. Required committees must report to the Medical Executive Committee regularly throughout the year according to the Bylaws and Organization and Functions Manual. The following committees serve required functions: Quality Assessment and Performance Improvement Committee (Includes Infection Control, Transfusion, and Surgical and Tissue Case Review), Joint Advisory Council/Function, and Credentials Committee. The names of committees may be changed from time to time so long as the purposes or functions required by accreditation standards remain the same. The composition, duties, and reporting structure of the foregoing committees and other committees (such as, but not limited to: Peer Review Committee, Medical Records Committee (Network and Hospital specific), Pharmacy and Therapeutic Committee, Tumor Board, Cancer Committee, Wellness Committee, Rules and Bylaws Committee, Nominating Committee, Graduate Medical Education Committee at teaching hospitals, Critical Care Committee, Disaster Committee, Distinguished Service Award Committee, and Trauma Committee) are as set forth in the Organization and Functions Manual, except for the Medical Executive Committee which is as set forth below. Nothing shall preclude joint meetings of Affiliate Hospitals' Medical Staff committees to the extent that such meetings will assist in assuring quality patient care and effective peer review.

In addition to the foregoing Hospital committees, there shall be the following required Network Committee: an overarching KHN Medical Staff Bylaws Alignment Committee composed of representatives of each Hospital, including the Chiefs of Staff, immediate past Chiefs of Staff, Chairs of the Bylaws Committees, and invitees as needed, with duties relevant to the formulation, review, amendment, adoption and recommendations made concerning these Bylaws as set forth at Section 13 of these Bylaws and as enumerated in the Alignment Committee's Charter, as may be amended from time to time.

SECTION 8.1. Medical Executive Committee (MEC)

8.1.1. Composition.[2]

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[1] GV also has an Osteopathic Practice Committee (Utilization of Osteopathic Methods and Concepts).

[2] **At GV with SV**, a majority of the members of the MEC must be doctors of osteopathic medicine.

(a) The voting members of the Medical Executive Committee shall consist of the officers of the Medical Staff, Chairs of all Clinical Departments, and Chairs of Sections comprised of eight (8) or more active members, three (3) members elected at large from the Active Staff, plus one (1) additional member representing a Clinical Department or Section for each thirty (30) active members of the Clinical Department or thirty (30) active members of a Section above the original eight (8) members necessary for initial representation. For each Section with at least thirty (30) active members and for each Clinical Department with at least thirty-eight (38) active members, if the total number of active members to be counted towards additional representation of a Clinical Department or Section is not evenly divisible by thirty (30), that Clinical Department or Section shall be entitled to one additional member on the MEC.

The composition of the MEC at each KHN Hospital is as determined by such Hospital as noted in the below footnote.

8.1.2. Duties.

The Medical Executive Committee supervises overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff or any of its clinical units as well as conducts periodic review of Medical Staff Bylaws, Organization and Functions Manual, Credentials Policy Manual, and Medical Staff policies; and makes recommendations for changes to the Medical Staff and to the Board as specified below. It is the responsibility of the MEC to initiate, conduct inquiries, initiate investigations, review, and report on corrective action, and on any other matters involving clinical, ethical, and/or professional conduct of any individual Practitioner. This responsibility may be delegated as a peer review activity to a quality review committee or a focused professional practice quality improvement panel committee selected by the Chief of Staff with the intent to improve the Practitioner's performance. The panel committee shall conduct the review as peers following the time frames set for that focused review by the MEC and report its findings to the MEC as directed.

The duties of the Medical Executive Committee shall be to:

(a) Represent and act on behalf of the Medical Staff when the Medical Staff cannot be assembled or in the intervals between general Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.

(b) All of the three (3) MEC members at large shall be elected at the appropriate Staff meeting for a two (2) year term. Members-at-large shall represent the Medical Staff membership and make Medical Staff recommendations as appropriate. At-large members shall be eligible for re-election, but shall not serve more than three (3) consecutive terms. If a vacancy occurs, it shall be filled at the next Medical Staff meeting.

(c) The President, the CMO and the Chair of the Credentials Committee shall be members of the MEC Ex Officio.

At KMCS, and at Soin with Greene, the majority of voting Members must be doctors of medicine or osteopathy and will include the Medical Staff officers and representatives from each Clinical Department (selected by the members of such Department for a two year term). The President/CEO, CMO, Vice President Patient Care Services (CNO), Medical Staff representative to the Organized Medical Staff Section of the American Medical Association, Director of Medical Education and a member representing the Board of Directors will be members Ex Officio. The Chief of Staff serves as Chair. All active Medical Staff Appointees, of any discipline or specialty, are eligible for membership on the MEC; provided, however, that, at all times, Physician Appointees of the Active Medical Staff shall comprise at least a majority of the voting members of the MEC.

At FHH, the majority of voting Members must be doctors of medicine or osteopathy and will include the Medical Staff officers; the Department Chairs; two (2) at large members of each of the Department of Medicine and the Department of Surgery selected in accordance with the Bylaws; the President (who shall be ex-officio without vote, and shall sit with the committee at all times except when it is in executive session); and the following Ex Officio members who sit with the MEC when able to attend: Vice-President of Finance, Vice-President of Nursing, and Director of Quality Management (or such other successor positions performing similar successor administrative/management roles).

(b) Receive and act upon reports and recommendations from Medical Staff committees, joint Hospital/Medical Staff committees, Clinical Departments, and assigned activity groups, and to make recommendation to the Board regarding the same, including the following Quality Assurance Performance Improvement (QAPI) functions:

- Medication therapy, including antibiotic and non-antibiotics for all service types (inpatient, outpatient, ambulatory, and emergency care) of patients;
- Infection control, including community acquired and healthcare acquired infections in patients and health care workers;
- Surgical/invasive and manipulative procedures, including tissues and non-tissue producing cases, with and without anesthesia and/or moderate sedation;
- Blood (including component) product usage;
- Data management (accuracy, currency, transferability) with emphasis on medical record pertinence and timeliness;
- Discharge planning and utilization review;
- Complaints regarding medical staff related issues;
- Restraint/seclusion usage; and
- Mortality review.

(c) Coordinate, provide leadership, and implement the professional, clinical, performance improvement (including customer satisfaction and patient safety), and organization activities and policies of the Medical Staff including peer review, which helps to create and maintain a culture of safety and quality throughout the Hospital.

(d) Act as liaison between the Medical Staff and the Chief of Staff.

(e) Recommend action to the Chief of Staff on matters of a medico-administrative nature and to recommend the Medical Staff organization structure to the Board.

(f) Make recommendations on Hospital management matters to the Board through its Professional Practice Committee or a successor committee having the same charge.

(g) Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation and licensure status of the Hospital.

(h) Fulfill the Medical Staff's accountability to the Board for the medical care rendered to patients in the Hospital.

(i) Design a mechanism to ensure that the same level of appropriate quality of patient care is provided by all individuals with privileges, within the Clinical Departments, across Clinical Departments, and between Appointees and non-Appointees who have Privileges during the patient's entire stay at the Hospital.

(j) Oversee the quality of patient care, treatment, and services provided by Practitioners and NPPs.

(k) Review the qualifications, credentials, performance, professional competence, and character of applicants, Appointees, Practitioners, and privileged NPPs, and to make recommendations to the Board regarding, appointment, reappointment, termination, assignments to Clinical Departments, Privileges, and corrective action.

(l) Request evaluations of a Practitioner's or NPP's Privileges through the Medical Staff process in instances where there is doubt as to such individual's ability to perform the Privileges requested.

(m) Take all reasonable steps to ensure ethical professional conduct and competent clinical performance on the part of Practitioners and NPPs with Privileges.

(n) Conduct such other functions as are necessary for the effective operation of the Medical Staff.

(o) Direct mechanisms for corrective action, including indications and procedures for automatic and summary suspension of an individual's appointment and/or Privileges.

(p) Establish mechanisms to provide effective communications among the Medical Staff, Hospital administration, the Board, and all levels of governance involved in policy decisions affecting patient care services in the Hospital.

(q) Establish mechanisms by which housestaff are supervised by Appointees in carrying out their patient care responsibilities.

(r) Report at each general Medical Staff meeting.

(s) Access and recommend to the relevant Hospital authority off-site sources for needed patient care services not provided by the Hospital.

(t) Make recommendations for the position of CMO to the Board of Directors from among the nominees.

(u) Make recommendations to the President/CEO and Board concerning the effect of proposed administrative actions on the quality and safety of patient care including, but not limited to, exclusive contracts prior to any such contract being offered, and of current exclusive contracts, on an ongoing basis.

8.1.3. Meetings, Reports and Recommendations.

The Medical Executive Committee will meet eight (8) times a year or more frequently as determined by the Chair. The Secretary will maintain a permanent file of the minutes, including a record of attendance and vote taken on each matter. The minutes should include the minutes of the various Clinical Departments, Sections and committees of the Staff. Copies of all minutes and reports of the Medical Executive Committee shall be transmitted to the Hospital President and the CMO routinely as prepared, and important actions of the Medical Executive Committee shall be reported to the Staff as a part of the Medical Executive Committee's report at each Staff meeting. Recommendations of the Medical Executive Committee shall be transmitted to the President and the Board as the committee deems appropriate. Except as otherwise stated herein, the MEC shall follow the "Provisions Common to All Meetings" as set forth in these Bylaws.

8.1.4 Privileges and Immunities

The MEC shall claim all privileges and immunities afforded to it under the law as a peer review committee, and shall maintain the confidentiality of all peer review records and communications as privileged information.

ARTICLE 9.

UNIFIED AND INTEGRATED MEDICAL STAFF OPTIONS

SECTION 9.1. IN GENERAL

This Hospital is a part of a multi-hospital network. In the event the Medical Staff is required by its Board to vote to either accept a unified shared integrated medical staff structure or to opt out of such a structure, the process to follow regarding such election is as described in this Article.

Section 9.2. VOTING TO ACCEPT OR REJECT A UNIFIED MEDICAL STAFF

The Medical Staff must initially vote to opt in or out of a Unified Medical Staff by such majority vote that is consistent with the method of amending these Bylaws as set forth in the Article regarding "Review, Revision, Adoption and Amendment" under the Section entitled "Medical Staff Action." Only Members holding privileges to practice on site at the Hospital may vote.

Section 9.3. UNIFIED GOVERNING DOCUMENTS

If the Medical Staff votes to accept unification, then its Medical Staff leaders and ex-officio hospital leaders shall convene with those of the other KHN Network Hospitals which medical staffs have also accepted unification to prepare and finalize one set of Unified Medical Staff governing documents that reflect the unique needs, circumstances, patient population and services of this and other member hospitals' medical staffs. These Bylaws will remain in effect until the new Unified Medical Staff governing documents are adopted pursuant to these Bylaws.

Recognizing the value of having medical staff governing documents ready for review at the time the affected medical staffs vote on whether to create a Unified Medical Staff, nothing in this Section precludes the Board from establishing various *ad hoc* committees, including joint medical staff committees, for the purpose of considering unification and the preparation of draft Unified Medical Staff documents prior to the Board electing to establish a Unified Medical Staff or at any time during the process.

Section 9.4. OPTING OUT

Should the Medical Staff elect to become part of a single unified Medical Staff, but at a later date wish to "opt out" of that relationship, it may call a vote to opt out of such Unified Medical Staff consistent with the methodology for opting out as set forth in its Unified Medical Staff Bylaws then in effect, which methodology shall not be inconsistent with the Medicare Conditions of Participation or its accrediting standards. The opt out decision may not be delegated to the executive committee of the Unified Medical Staff. Members will be advised at least annually in writing of their rights to opt out of the Unified Medical Staff at the annual Medical Staff meeting.

ARTICLE 10.

PROCEDURE FOR INQUIRY, INVESTIGATION OR CORRECTIVE ACTION

SECTION 10.1. Grounds for Action

Grounds for an informal inquiry, a formal investigation and/or corrective action shall exist whenever three of the following individuals: the Chief of Staff, the CMO, the Chair of the appropriate Clinical Department or Section, the Chair of the Hospital Board or the Hospital President, or their designees, by unanimous action, have cause to question, with respect to an individual holding a current Medical Staff appointment:

(a) the Appointee's clinical competence,
(b) the Appointee's care or management of a patient(s),
(c) the Appointee's violation of the bylaws or policies of the Hospital, the Medical Staff Bylaws, Policies, Rules or Regulations,
(d) the Appointee's violation of the ethics prescribed by the Appointee's profession,
(e) unauthorized release of peer review information;
(f) failure to comply with standards of quality medical care which recognize the efficient and effective utilization of Hospital resources;
(g) corrective action of another health care entity;
(h) the Appointee's behavior that is offensive, disruptive or detrimental to the operation of the Hospital or patient care; and/or
(i) the mental, emotional or physical health of the Appointee (with the option of referral to the Wellness Committee).

The aforementioned are intended to be representative of issues which may generate a request for corrective action, but are not all inclusive. In the event of disruptive behavior, the first course of action should be to consider and initiate the Disruptive Physician Three-Step Process as outlined in these Bylaws, depending on the nature, severity and frequency of the behavior.

The Chief of Staff or Chair of the appropriate Clinical Department or Section may conduct an informal, initial review of the facts and circumstances to determine the appropriate course of action to handle the concern, which may include, without limitation: (i) referral to other Hospital processes designed to handle the matter; (ii) referral to an informal resolution process within the appropriate Clinical Department or Section; (iii) a determination that no basis exists to proceed further, or (iv) referral to the MEC.

Formal investigations and informal inquiries and reviews, including the Disruptive Physician Three-Step Process, and all proceedings, information, and records in connection with such, are considered peer review activities and are intended to be subject to the protection of Ohio's peer review privilege statutes as set forth at Ohio Rev. Code § 2305.24, § 2305.252, and § 2305.253, all as may be amended.

SECTION 10.2. Disruptive Physician Three-Step Process

For alleged offenses regarding a physician's disruptive behavior as outlined in these Bylaws (see Organization and Functions Manual for definition of "disruptive physician"), the following steps will be followed which are not considered adverse actions and do not confer due process rights to the Appointee under these Bylaws:

Step 1:
On the first alleged offense, the CMO and/or Chief of Staff will be informed of the allegations. A conference will occur between the CMO and the Chief of Staff at which time a decision will be made as to whether: (a) the case warrants an inquiry, or (b) the case should be dismissed. It is emphasized that this Three-Step Process is not a formal investigation and gives no due process rights under the Bylaws. Should both the CMO and the Chief of Staff agree the allegation merits further inquiry, the CMO shall obtain from the parties directly involved a written synopsis of the disruptive behavior to substantiate the claim outlining when, where, and under what circumstances this event occurred. Only unsolicited information from the primary source of the complaint or those directly observing the incident will be accepted. Upon receipt of this information, the physician involved will be requested to attend a meeting held by the CMO, Chief of Staff, and Department Chair acting as a peer review committee, and at which point these allegations will be brought to the physician's attention. Upon conclusion of this meeting the CMO, Chief of Staff, Department Chair and the physician involved will decide if a 28-day observation period to include a follow-up meeting with the CMO and Chief of Staff to monitor and discuss the physician's behavior, and a formal letter outlining the offense should be placed in their administrative file. The matter can then be considered resolved upon satisfactory completion of the observation period. If the physician involved feels this resolution to be unsatisfactory, this individual can request a hearing at the next Medical Executive Committee meeting and present the case where the MEC will be the final determining body as to whether the problem warrants a 28-day observation period and a formal letter placed in the file, or if the matter is undeserving of such action and the matter will be considered resolved with no further action..

Step 2:
If Step 1 results in an observation period and formal letter, then should a second disruptive offense occur by the same physician during the ensuing three-year period, the CMO and/or Chief of Staff will be informed of the allegations. A written synopsis shall again be obtained from the parties directly involved with the disruptive behavior. Only unsolicited information from the primary source of the complaint or those directly observing the incident will be accepted. Upon receipt of this information, the physician involved will be requested to attend a meeting held by the CMO, Chief of Staff, and Department Chair acting as a peer review committee, and at which point these allegations will be brought to the physician's attention. Upon conclusion of this meeting the CMO, Chief of Staff, Department Chair and the physician involved will decide if a 28-day observation period to include a follow-up meeting with the CMO and Chief of Staff to monitor and discuss the physician's behavior, and a second formal letter outlining the offense should be placed in the physician's administrative file. If the physician involved feels this resolution to be unsatisfactory, s/he can request a hearing at the next MEC meeting and present the case where the MEC will be the final determining body as to whether the problem warrants a 28-day observation period and a

second formal letter placed in the file, or if the matter is undeserving of such action and the matter will be considered resolved with no further action..

Step 3:
Should a third disruptive offense by the same physician during the original inception of the three-year period be brought to the attention of the CMO and/or the Chief of Staff, the physician involved will be asked to report directly to the next MEC meeting for a presentation of the facts from the written synopsis of all three events with the physician involved relating his/her account of the events. A decision will then be made by the MEC as to whether: (a) any action is warranted, or (b) if the action warranted should be educational in nature, or involve counseling, or warrant a suspension of privileges. If the physician involved successfully completes the program as outlined by the MEC per the MEC Chair, the matter will be considered resolved. If he or she does not complete this plan to the satisfaction of the MEC, per the Chair of the MEC, a continuation of education, counseling and/or suspension can proceed.

Purge: If the said three year period ends with no further disruptive actions or complaints regarding the physician, his/her administrative file shall be purged of any said related complaints and letters..

SECTION 10.3. Informal Inquiry

Concerns may arise from time to time concerning an Appointee's clinical judgment or performance, or professional conduct that, in the judgment of the Chief of Staff, CMO, and Appointee's Clinical Department or Section Chair, may be susceptible to an informal resolution process. When appropriate, this course of action should be the first consideration before recommending to the MEC that it consider a formal investigation process regarding such concerns.

When initiating an informal inquiry, the involved Appointee shall be invited to be interviewed by two or more of the Chief of Staff, CMO, and/or Appointee's Clinical Department or Section Chair (or designees). At such interview, circumstances prompting the informal inquiry should be discussed, and the Appointee asked to present relevant information on his/her own behalf.

Nothing in this Article shall be construed as obligating the Medical Staff leadership or Hospital to engage in informal remediation prior to implementing a formal investigation or other corrective action. Informal Inquiries, including the three-Step Process, are not considered adverse actions and do not confer due process rights under these Bylaws to the Appointee.

10.3.1. Effect of Informal Inquiry.

If the involved Appointee's action(s) is not subject to the Three-Step Process, Automatic Suspension, or Summary Suspension, the individuals conducting the informal inquiry will recommend to the Chief of Staff that the matter in question be considered resolved or be referred to the MEC for further review or formal investigation.

10.3.2. Written Record.

A written summary shall be maintained for each informal inquiry. The summary shall identify the persons conducting the informal inquiry, a summary of the physician's actions (including pertinent dates) that prompted the informal inquiry, a summary of the interview with the Appointee (if so conducted), and the effect of the informal investigation. The Appointee will be provided with a copy of this written summary.

10.3.3. Informal Inquiry Relating to Hospital Employee Complaint.

If the circumstances prompting an informal investigation arise out of a Hospital employee's report or allegation of Appointee misconduct, the Medical Staff's informal investigation process may, at the discretion of the CMO and/or President/CEO or his/her designee, also serve to satisfy certain Hospital administrative policies regarding an employee's report or allegation of misconduct, unless otherwise stated in such policies. In such instance, the identity of such employee shall be protected to the extent accorded by applicable Hospital policies; and if the Appointee knows or has a reasonable suspicion as to the identity of such employee, the Appointee is prohibited from contacting the employee regarding such report or allegation, it is the responsibility of the CMO and/or the President/CEO or his/her designee, to notify the Appointee of such prohibition.

SECTION 10.4. Formal Investigation Procedure

10.4.1. Notice and Request.

A voting member of the MEC, Board Member, Chief of Staff, CMO, Chair of appropriate Clinical Department, or the President/CEO may request the MEC to initiate a Formal Investigation regarding the necessity or advisability of corrective action against an Appointee. All requests for a Formal Investigation must be in writing, which may be reflected by minutes submitted to or created by the MEC, and supported by reference to specific activities or conduct that constitute grounds for the request. The Chief of Staff shall promptly notify the President/CEO of all such requests.

10.4.2. Criteria for Initiation of Formal Investigation.

Upon notice or request to the MEC in accordance with this Section, and after consideration of the efficacy of informal remediation under this Article, the MEC, by majority vote, may initiate a Formal Investigation where there is reliable information that an Appointee may have exhibited acts, demeanor, or conduct that is or is reasonably likely to be:

(a) detrimental to patient safety or to the delivery of quality patient care within the Hospital;

(b) a violation of the ethics prescribed by the Appointee's profession;

(c) contrary to the bylaws or policies of the Hospital or Medical Staff Bylaws, Policies, Rules or Regulations;

(d) below applicable professional standards of behavior or clinical management; or

(e) is the subject of a felony conviction of any degree if such adversely affects the Appointee's license to practice in the State of Ohio.

10.4.3. Procedure for Formal Investigation.

The MEC shall meet as soon after receiving the request for Formal Investigation as is practicable and if, in the opinion of the MEC, the request for a Formal Investigation contains on its face sufficient information to warrant action or investigation, the MEC shall immediately appoint an investigating committee ("ad hoc committee") to do so, which committee acts as a peer review committee. The ad hoc committee shall consist of at least three (3) persons of equivalent credentialing who may or may not hold appointment to the Medical Staff and must have at least one Medical Staff Officer. The ad hoc committee shall also include any other individuals (who may or may not be Medical Staff members) as is required by relevant Hospital policy. Non-members of the MEC may be utilized in the investigation process in accordance with relevant Hospital policy and provided appropriate steps are taken to assure that the activities of such a non-member, as related to the investigatory process, are protected by the Ohio Peer Review Privilege Statute and other relevant law. The ad hoc committee shall not include as members anyone that is a partner or associate of those members sitting on the Medical Executive Committee, or who is in economic competition with the Appointee or otherwise has a conflict of interest. The ad hoc committee shall have available the full resources of the Medical Staff and the Hospital to aid in their work, as well as the authority to use outside consultants as required. The Appointee being investigated will be promptly notified of the investigation and the reason for such investigation and shall be given an opportunity to meet with the ad hoc committee before it makes its report. Prior to this meeting of the ad hoc committee, the individual shall be informed of the charge and the evidence supporting the Formal Investigation requested, shall be provided access to any medical records involved in the Formal Investigation, and shall be invited to discuss, explain or refute the basis of the Formal Investigation. The investigative process, including any interviews conducted, do not constitute a "hearing" as that term is used in these Bylaws and shall not entitle the Appointee to the procedural rights provided under these Bylaws. A summary record of such interview with the affected Appointee shall be made by the ad hoc committee and included with its report to the MEC. The Formal Investigation shall be completed and the report submitted to the MEC within thirty (30) days. The MEC shall then make its recommendation to the individual. At any time during the Formal Investigation the Medical Executive Committee may suspend all or any part of the clinical privileges of the person being investigated. This suspension shall be deemed to be administrative in nature, for the protection of hospital patients. It shall remain in effect during the Formal Investigation only, without appeal, but in no event for longer than fourteen (14) days, and shall not be an indication of the validity of the charges. If such a suspension is placed into effect, the Formal Investigation shall be completed within fourteen (14) days. Nothing in this section shall limit or preclude the imposition of a summary suspension pursuant to these Bylaws. The MEC may, at any time within its discretion, terminate the investigation process and proceed with action as provided at subsection 10.4.4 below.

The Appointee is not entitled to be represented by an attorney or other representative at any interview, meeting, review, informal investigation, Formal Investigation, or other proceeding or process that takes place prior to a formal "hearing" as that term is used in these Bylaws under due process rights.

Unless otherwise required by law or Hospital policy, during the Formal Investigation concerning alleged Appointee misconduct based upon a report of such conduct by a Hospital employee, the identity of such employee shall not be disclosed to the Appointee or any other person on behalf of the Appointee, and such employee shall not be contacted, directly or indirectly, by the Appointee or his/her attorney or any other person on behalf of the Appointee where such employee is a current employee of the Hospital. During such Formal Investigation, the Appointee shall be informed as to the general and specific allegations of any employee's allegations; and may contact the President/CEO to request assistance in clarifying any aspect of the employee's report of alleged misconduct.

If the ad hoc committee has reason to believe that the Appointee's conduct giving rise to the request for corrective action was the result of a physical or mental impairment, the MEC may either refer the matter to the Medical Staff Wellness Committee or require the Appointee to undergo an impartial physical or mental evaluation within a specified time and pursuant to guidelines set forth in the Medical Staff policy regarding impaired physicians. The MEC shall provide names of qualified independent third party Practitioners who may be asked to conduct the examination at the Appointee's expense.

10.4.4. Medical Executive Committee Action.
As soon as is practical after the conclusion of the investigative process, but in any event at its next meeting unless deferred, the MEC must act upon the recommendation of such investigative action. Its action may include without limitation:

(a) Determining that no corrective action be taken.

(b) Deferring action for a reasonable time where circumstances warrant.

(c) Issuing a letter of admonition, censure, reprimand, or warning, In the event such letter is issued, the affected Practitioner may make a written response that shall be placed in the Practitioner's file.

(d) Imposition of a probationary period with retrospective review of cases and/or other review of professional behavior, but without a requirement of prior or concurrent consultation or direct supervision.

(e) Recommending the imposition of prior or concurrent consultation, direct supervision, or other form of probation that limits the Appointee's ability to exercise Privileges for a specified time period (not to exceed one (1) year).

(f) Referring the matter to the Medical Staff Wellness Committee for evaluation and action as appropriate for the Practitioner's condition.

(g) Recommending reduction, suspension, or revocation of all, or any part, of the Practitioner's Privileges.

(h) Recommending reduction of Medical Staff category or limitation of any Medical Staff Prerogatives directly related to the Practitioner's delivery of patient care, or suspension or revocation of Medical Staff appointment.

(i) Take other actions deemed appropriate under the circumstances including summary suspension.

10.4.5. Procedural Rights.

A MEC recommendation pursuant to (e) through (i) above may be deemed Adverse and entitle an affected Appointee to the procedural rights contained in these Bylaws when such restriction or revocation lasts more than 30 days. If Adverse action is taken or recommended, the Appointee must exhaust the remedies afforded by these Bylaws before resorting to legal action.

10.4.6. Board Notification.

A MEC recommendation or action that does not limit the ability of an Appointee to exercise his or her Prerogatives of appointment or Privileges is not deemed Adverse and shall be transmitted to the Board together with all supporting documentation for informational purposes.

10.4.7. Summary Suspension; Automatic Suspension/Termination Not Precluded..

The commencement of corrective action procedures against an Appointee shall not preclude the summary suspension, or automatic suspension or termination of the Medical Staff appointment and/or all, or any portion of, the Appointee's Privileges in accordance with the procedures set forth below in this Article.

SECTION 10.5. AUTOMATIC SUSPENSION OR LIMITATION

10.5.1. Imposition of Automatic Suspension or Limitation and Subsequent Process.

The following events shall result in an automatic suspension or limitation of appointment and/or Privileges without recourse to the procedural rights set forth in these Bylaws:

(a) Licensure. Action by any federal or state authority suspending or limiting an Appointee's professional license shall result in an automatic comparable suspension/limitation on the Appointee's Privileges. Whenever an Appointee's licensure is made subject to probation, the Appointee's right to practice shall automatically become subject to the same terms of the probation. The imposition by the Ohio State Medical Board of any restriction or condition shall give rise to a formal investigation pursuant to these Bylaws.

(b) Controlled Substance Authorization. Whenever an Appointee's federal or state controlled substance certificate is suspended, limited, or revoked, lapsed, or not renewed, the Appointee shall automatically and correspondingly be limited of the right to prescribe medications covered by the certificate as of the time such action becomes effective and through its term. Whenever an Appointee's state or federal controlled substance certificate is made subject to probation, the

Appointee's right to prescribe such medications shall automatically become subject to the same terms of the probation.

(c) Professional Liability Insurance Coverage. If an Appointee's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the Appointee's granted admitting and clinical privileges shall be automatically suspended until valid coverage is obtained (including any necessary gap coverage) and becomes effective and the Hospital is provided with proof of required coverage and a written statement from the Appointee (i) explaining the circumstances of the previous insurance being canceled or not renewed, and any limitations on the new policy; and (ii) providing a summary of relevant activities during the period of no coverage to establish current competency. Suspension shall not apply if the Appointee has timely requested a waiver or reduction of such coverage in connection with changed circumstances in compliance with law and these Bylaws, and is awaiting final action on such request.

(d) Federal Health Care Program. Whenever an Appointee is suspended, for cause, from participating in a federal health care program, the Appointee's privileges shall be immediately and automatically suspended. Voluntary non-participation or exclusion for contractual non-participation would not be grounds for suspension/termination.

(e) Failure to Provide Requested Information. Failure to provide required/requested information pursuant to a written request by the MEC or the President/CEO as set forth herein shall result in automatic suspension of all Privileges until such information is provided. For purposes of this section, "required/requested information" may include but not be limited to: (i) physical or mental examination reports if authorized by these Bylaws, or (ii) information regarding a conflict of interest.

(f) Failure to Satisfy Continuing Education Requirements. Failure to complete mandated state licensure continuing education requirements shall result in automatic suspension of the Appointee's Privileges and Prerogatives until such time as the requirements are met.

(g) Failure to Pay Dues/Assessments. Failure to pay Medical Staff dues or fines as required within ninety (90) days after notice that such dues or fines are due shall result in an automatic suspension of the Appointees' privileges until such time as the dues or fines are paid.

(h) Failure to Obtain NPI. Failure to obtain a National Provider Identifier ("NPI"), which is required as part of the administrative simplification section of the Health Insurance Portability and Accountability Act shall result in the automatic suspension of the Appointee's Privileges until such time as the NPI is obtained.

(i) Failure to Complete Medical Records. Whenever an Appointee fails to complete medical records in accordance with applicable policy, rules and regulations, the Appointee shall be automatically suspended consistent with such policy.

(j) Contractual. When the Hospital elects to enter into an exclusive contract for the provision of certain services, an affected Appointee who is not a party to the exclusive arrangement shall not

be able to exercise privileges granted in the certain service, unless specifically approved by the Board for exceptional circumstances upon reapplication.

(k) Health Evaluation. An Appointee who fails to submit to a physical or mental health evaluation (including substance abuse evaluation) within sixty (60) days of a written request therefor by the Board based on evidence of need for the evaluation supplied to the Board by the MEC, shall automatically be suspended from practicing at the Hospital until the evaluation occurs. If the Appointee fails to submit to such evaluation and furnish the Hospital with the results thereof within ninety (90) days after being suspended, the Appointee's Medical Staff membership and Privileges shall terminate automatically.

(l) Action At Another KHN Hospital. If an Appointee's Privileges are summarily suspended or restricted at another Affiliate Hospital, such Appointee's Privileges at this Hospital shall automatically be subject to the same restriction or suspension until lifted at such other Affiliate Hospital, subject to this Medical Staff's/Hospital's right to take any appropriate action provided for in these Bylaws. If an Appointee's Medical Staff membership or Privileges at another Affiliate Hospital is/are terminated, limited, or subject to conditions, the Appointee's or applicant's status at this Hospital shall automatically be subject to the same action/limitation(s). As soon as practically possible, but within two (2) business days of the action, the Manager of the Medical Staff Services Department of the Hospital that took such action shall notify the Managers of the Medical Staff Services Departments at the other Affiliate Hospitals of such action, and those Managers will then communicate same to their respective Chiefs of Staff and CMOs. This Section shall not be triggered by action at another Affiliate Hospital that is based solely on the grounds described in Section 10.5.1 (g) regarding dues or 10.5.1 (i) regarding medical records.

(m) Immunizations/Health Screenings. Failure to provide documentation of required immunizations and/or health screenings (or an approved exemption therefrom) in accordance with the requirements set forth in the applicable Hospital/Medical Staff policies will result in an automatic suspension of the Practitioner's or NPP's appointment and/or Privileges subject to §10.6.8 below.

10.5.2. Impact of Automatic Suspension/Limitation.

During such period of time when an Appointee's privileges are suspended or limited, he/she may not exercise any Prerogatives of appointment or exercise any Privileges at the Hospital, participate in Emergency Department call (with the exception of an automatic suspension for delinquent medical records), schedule surgery, or otherwise provide professional services within the Hospital for patients, nor can he or she render professional care except as follows:

(a) To conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the suspension of Privileges.

(b) To attend an obstetrical patient who has been under his or her active care and management and who comes to term and is admitted to the Hospital in labor.

(c) To attend to the management of any patient under his or her care whose admission or outpatient procedure was scheduled prior to the effective date of the suspension.

(d) To attend to the management of any patient requiring emergency care and intervention.

10.5.3. Action Following Imposition of Automatic Suspension or Limitation.

As soon as practical after the imposition of an automatic suspension or limitation, the MEC shall convene to determine if further corrective action is necessary in accordance with this Article. The lifting of the action or inaction that gave rise to an automatic suspension or limitation of the Appointee's privileges shall result in the automatic reinstatement of such privileges; provided, however, that to the extent the suspension or limitation remained in effect for a period of more than thirty (30) days, the Appointee shall be obligated to provide such information as the Medical Staff Services Department shall reasonably request to assure that all information in the Appointee's credentials file is current.

SECTION 10.6. AUTOMATIC TERMINATION.

The following events shall result in an automatic termination of an Appointee's Privileges without recourse to the procedural rights set forth in these Bylaw, and the practitioner may reapply for membership and/or Privileges, as applicable, upon curing the event or failure, and has the burden of demonstrating that s/he meets the standards for such:

10.6.1. Licensure. Action by any federal or the Ohio State Medical Board, or by a court of competent jurisdiction terminating an Appointee's professional license, or Appointee's failure to renew his/her license shall result in an automatic termination of the Appointee's Privileges.

10.6.2. Professional Liability Insurance. If a Appointee's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect for a period greater than sixty (60) days, the Appointee's Privileges shall automatically terminate as of the sixty-first (61st) day. Termination shall not apply if the Appointee has timely requested a waiver or reduction of such coverage in connection with changed circumstances in compliance with law and these Bylaws and is awaiting final action on such request.

10.6.3. Federal Health Program. Whenever an Appointee is excluded, for cause, from participating in a federal health care program, the Appointee's Privileges shall be automatically terminated. Voluntary non-participation or exclusion for contractual non-participation would not be grounds for suspension/termination.

10.6.4. Illegal Conduct. If an Appointee pleads guilty to, or is found guilty of, a felony of any degree, or other serious offenses involving violence or abuse upon a person, or conversion, embezzlement, misappropriation of property, fraud, bribery, tampering, perjury, drug offense, or conduct that is considered contrary to community standards of justice, honesty or good morals, then the Appointee's Privileges shall be immediately and automatically terminated; provided, however, if the behavior that triggered the conviction is based upon Practitioner impairment, then

the matter shall be referred to the Medical Staff Wellness Committee for consideration and recommendation to the MEC as to what action should be taken.

10.6.5. Contracts. If an Appointee has a contractual arrangement with the Hospital, or through employment or other arrangement with a group that has a contractual arrangement with the Hospital, the terms and conditions of the contract will govern the obligations of the Hospital and Medical Staff relative to corrective action or automatic termination under these Bylaws; and will supersede the due process rights of the Appointee as set forth in these Bylaws to the extent that such due process rights are in conflict with the terms and conditions of the contractual arrangement.

10.6.6. Moving Without Notice. When the Practitioner moves from and out of the KHN service area (so that s/he can no longer participate in membership and/or Privileges) without notice to the Hospital, his/her appointment and/or privileges, as is relevant, may be automatically terminated after Notice is sent to the last known address with opportunity to respond within 30 days of the date such Notice was sent.

10.6.7. DEA Registration or State Controlled Substances License. If an Appointee's DEA registration or Ohio Controlled Substance license is revoked or otherwise terminated, or is suspended, restricted or lapsed for more than sixty (60) consecutive days, the Appointee's Medical Staff membership and Privileges shall automatically terminate unless such Appointee is exempt from maintaining such registration or license by Medical Staff policies and procedures.

10.6.8. Immunizations & Health Screenings. In the event that documentation of required immunizations and/or health screenings (or an approved exemption therefrom) is not provided within ninety (90) days following the date of an automatic suspension of Medical Staff appointment and/or Privileges pursuant to §10.5.1 (m), the Practitioner's or NPP's appointment and/or Privileges shall automatically terminate as of the ninety-first (91st) day.

SECTION 10.7. SUMMARY SUSPENSION

10.7.1. Initiation. A summary suspension may be initiated by the MEC or the Board or any two of the following individual's: an officer of the Medical Staff, Board Chair, President/CEO, or a Clinical Department or Section Chair with respect to Appointees in that Clinical Department or Section. Each has the authority to summarily suspend the Medical Staff appointment and/or suspend or restrict all, or any portion of, the Privileges of an Appointee whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual on the Hospital campus. Such summary suspension/restriction shall be deemed an interim precautionary step during review of the matter, and not a final finding of responsibility for the situation that caused the suspension.

10.7.2. Effective Date. Such suspension/restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the President/CEO (unless imposed by the President/CEO) who will inform the Board and the Chief of Staff. The President/CEO must give prompt written notice, by Special Notice, of the suspension to the Appointee. Such suspension/restriction shall remain in effect unless or until modified by the Chief of Staff or the Board.

10.7.3. Medical Executive Committee Action. As soon as convenient, but in no event later than 5 business days after a summary suspension is imposed, the MEC, if it did not impose the summary suspension, shall convene to review and consider the need, if any, for a professional review action. Such a meeting of the MEC shall not be considered a "hearing" as contemplated under due process rights of these Bylaws, even if the Appointee involved attends the meeting, and no procedural rights shall apply. The MEC may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the Board or the President/CEO. In the case of such summary suspension imposed by the Board or President/CEO, the MEC shall give its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated. The Board may accept, modify, or reject the MEC's recommendation. No later than fourteen (14) days following the original imposition of the summary suspension, the Appointee shall be advised, by Special Notice, of the MEC's determination or, in the case of a summary suspension imposed by the Board or President/CEO, of the MEC's recommendation as to whether such suspension should be terminated, modified, or sustained, and of the Appointee's due process rights, if any, pursuant to the Bylaws.

10.7.4. Procedural Rights. Unless the MEC promptly terminates the summary restriction or suspension within fourteen (14) days of its imposition, the Summary Suspension is deemed an Adverse Action and the Practitioner shall be entitled to the procedural rights afforded under the Bylaws. The terms of the summary suspension or restriction as sustained or modified by the MEC shall remain in effect pending a final decision thereon by the Board.

10.7.5. Other Action. A MEC recommendation to terminate or modify the suspension to a lesser sanction not triggering procedural rights must be transmitted, together with all supporting documentation, to the Board. In this instance, the MEC's recommendation will have the effect of immediately revoking the summary suspension completely or reinstating the Appointee with whatever corrective action was assessed by the MEC pending the final decision of the Board.

SECTION 10.8. CONTINUITY OF PATIENT CARE

Upon the imposition of a summary suspension, an automatic suspension or limitation, or an automatic termination, and in the event that another member of the Practitioner's group is unable to assume care of a suspended/terminated Practitioner's patients then in the Hospital, such patients must be assigned to another Practitioner by an officer of the Medical Staff or the appropriate Clinical Department Chair, and all relevant Chairs of Clinical Departments or Sections shall cooperate both in making arrangements for such coverage and in strictly enforcing such automatic suspensions or terminations of which the Emergency Department and the admitting office shall be promptly notified. The wishes of the patient should be considered in choosing a substitute Practitioner when feasible.

ARTICLE 11.

CORRECTIVE ACTION

SECTION 11.1. INITIATION OF HEARING

Unless waived, an applicant to or an Appointee of the Medical Staff with clinical Privileges shall be entitled to a hearing when an Adverse recommendation or action has been made or taken by the MEC or the Board. The hearing shall be conducted pursuant to this Article. No applicant or Appointee shall be entitled as a matter of right to more than one (1) hearing with respect to the subject matter of any proposed Adverse recommendation or action giving rise to a hearing right. The Practitioner must exhaust all remedies afforded by these Bylaws before resorting to legal action.

SECTION 11.2. THE HEARING

11.2.1. Initiation of Hearing. An applicant or a person holding a Medical Staff appointment shall be entitled to a formal hearing whenever a recommendation unfavorable to him/her regarding those matters enumerated in this Section under "Grounds for Hearing" has been made by the MEC. The purpose of the hearing shall be to recommend a course of action to those acting for the Hospital, whether Medical Staff or Board, and the duties of the Hearing Panel shall be so defined and so carried out.

11.2.2. Notice of Recommendation. When a recommendation is made which, according to those matters enumerated in this Section under "Grounds for Hearing," entitles an individual to one formal hearing prior to a final decision of the Board, the applicant or Appointee, as the case may be, shall promptly be given Special Notice by the President/CEO or the CMO. Such notice shall contain a statement of the recommendation pending, a statement of the reasons for the recommendation, and a summary of the applicant's or Appointee's due process rights enumerated in these Bylaws under this Section entitled "Hearings". If pertinent, patient records or information supporting the recommendation shall be identified and provided. This statement of the recommendation pending may be amended or added to at any time, even during the hearing, so long as the material is relevant to the continued appointment or Clinical Privileges of the individual requesting the hearing and the individual is given sufficient time to study this additional information and rebut it. Such individual shall have thirty (30) days following the date of the receipt of such notice within which to request a hearing by the Hearing Panel hereinafter referred to. Said request shall be made by notice to the Chief of Staff. In the event the affected individual does not request a hearing within the time and in the manner hereinabove set forth, the individual shall be deemed to have waived his/her right to such hearing and to have accepted the recommendation pending and it shall thereupon become effective immediately after Board decision.

11.2.3. Grounds for Hearing. Unless deemed necessary by the Chief of Staff or otherwise stated in these Bylaws, no recommendation other than those hereinafter enumerated shall constitute grounds for a hearing:

(a) denial of initial Professional Staff appointment;

(b) denial of requested advancement in Professional Staff category;

(c) denial of Professional Staff reappointment;

(d) revocation of Professional Staff appointment;

(e) denial of requested initial Clinical Privileges;

(f) decrease of Clinical Privileges;

(g) suspension of some or all Clinical Privileges for a period of more than thirty (30) days;

(h) imposition of a requirement for mandatory consultation requiring prior approval for a period of more than thirty (30) days.

SECTION 11.3. Actions Not Adverse and Do Not Give Rise to a Hearing..

Unless otherwise stated herein, the following shall not constitute grounds for a hearing or appeal, but shall take effect without hearing or appeal: voluntary relinquishment or automatic forfeiture of Clinical Privileges as provided for elsewhere herein; the imposition of observation, focused review, monitoring, proctoring, educational or training requirements, consultation or review requirements, or any other corrective, instructive, or automatic action which does not restrict Privileges for more than 30 days and is not reportable to the National Practitioners Data Bank, no matter whether such actions are imposed by the MEC, the Medical Staff or the Board,

SECTION 11.4. Time and Place for Hearing and Preliminary Matters

Within 15 calendar days of receipt of request for hearing, the Chief of Staff shall schedule the hearing and shall give notice by Special Notice to the person who requested the hearing, hereinafter called the "petitioner," of its time, place and date. This notice also shall include a list of witnesses expected to testify at the hearing on behalf of the Medical Staff or Hospital. The hearing shall begin as soon as possible considering the schedules and availability of all concerned but no earlier than sixty (60) days after the date of the President/CEO's Special Notice. If the Practitioner is under summary suspension, the hearing may begin sooner if schedules and availability of all concerned permit.

Where two or more KHN Hospitals take or recommend action against a single Practitioner based upon the same or similar facts and circumstances, and the Practitioner requests a hearing, the Chiefs of Staff of the affected Hospitals may, at the discretion and unanimous agreement of the involved MECs and Presidents/CEOs, jointly arrange and schedule the time and place of a joint hearing. Upon consideration of the recommendations of each involved MEC and President/CEO, and in accordance with this Article, such Chiefs of Staff will also determine the composition of the Hearing Panel, as well as the Presiding Officer and Hearing Officer (if any). A single Special

Notice of hearing dates and other above listed particulars to the Practitioner is sufficient. If a joint hearing is held, the petitioner is entitled to only the one (1) joint hearing, and not a hearing at each of the affected Hospitals. The initiating body of each Hospital that issued the Adverse recommendation/action (MEC or Board) receives the joint hearing report and recommendation, with all final determinations being made by each affected Hospital's Board in accordance with these Bylaws.

As a part of, or together with, the notice of hearing, the petitioner shall be given, in writing, further particulars regarding the acts or omissions with which he is charged, a list of the charts, if any, in question, and the pending recommendation that is being challenged by the requested hearing, or the reasons for the denial of a request made by the petitioner.

If either the petitioner or the Hospital, by notice, requests a list of witnesses, the other party, within 30 days of such request, shall furnish a written list of the names and addresses of the individuals who, so far as is then reasonably known, will give testimony or evidence in support of that party at the hearing, and the names and addresses of additional witnesses as soon as procured. The witness list of either party may, in the discretion of the hearing officer, be supplemented at any time during the course of the hearing.

The parties shall cooperate in the exchange of exhibits reasonably in advance of the hearing date. Prior to any exchange of exhibits, the parties must agree that all such documents will be maintained as confidential peer review documents and not be disclosed or used for any purpose other than the hearing and appeals related thereto.

All objections to witnesses or exhibits to the extent then reasonably known, shall be submitted to the presiding officer in writing in advance of the hearing.

Each party remains under a continuing obligation to provide to the other party any exhibits or witnesses identified after the initial exchange which a party intends to introduce at the hearing. The introduction of any exhibits not provided prior to the hearing, or the admissibility of testimony to be presented by a witness not so listed, shall be at the discretion of the presiding officer.

SECTION 11.5. Hearing Panel.

When a hearing is requested, the MEC and the President/CEO shall appoint a Hearing Panel to conduct the hearing which shall be composed of not less than five (5) Appointees of the Active Staff who are not in direct economic competition with the petitioner and who have not acted as accuser, investigator, fact finder, initial decision-maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action, including representation of the petitioner's discipline if deemed appropriate by the MEC and President/CEO. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Hearing Panel, but where professional competency or clinical quality is at issue, the Hearing Panel must include at least one physician who is in the same or similar specialty as the petitioner. Such appointment shall include designation of the Chair. A majority of the Hearing Panel, but no fewer than the greater of three (3) or two-thirds (2/3s) of the members at any one time, must be present throughout the hearing and deliberations. If a panel member is

absent from any significant part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision, unless otherwise agreed to by both parties. An alternate shall be disqualified if not present at all times.

SECTION 11.6. Hearing Officer.

The President/CEO and the MEC may appoint an impartial Hearing Officer (who may or may not be an attorney at law) to be a legal advisor to the Hearing Panel, but must not act as a prosecuting officer or as an advocate for the Hospital. The Hearing Officer may participate in the private deliberations of the Hearing Panel, but shall not be entitled to vote on its recommendations.

Section 11.7. Presiding Officer.

The President/CEO and the MEC shall appoint an impartial presiding officer of the hearing who is experienced in conducting administrative hearings and in particular peer review hearings and is knowledgeable regarding HCQIA and Ohio law. The presiding officer may be an Appointee, or an individual from outside the Hospital qualified to conduct the hearing. The petitioner shall be notified of the name of the prospective presiding officer and if he/she has an objection, he/she shall, within 5 calendar days after notification, state the objection and reason therefor in writing. The President and Chief of Staff, after considering such objection, shall decide, in their sole discretion, whether to uphold the objection and replace the presiding officer.

The presiding officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing and that no intimidation is permitted. The presiding officer shall determine the order of procedure throughout the hearing, and shall have the authority and discretion to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence, upon which the presiding officer may be advised by legal counsel. In all instances the presiding officer shall act in such a way that all information relevant to the continued appointment or Clinical Privileges of the petitioner is considered by the Hearing Panel in formulating its recommendations. It is understood that the presiding officer is relaying all relevant information to the Hearing Panel for its deliberations. In the event that an attorney serves as the hearing officer on the Hearing Panel, or as a presiding officer of the hearing, he/she must not represent the Hospital or its Medical Staff or other clients who are in direct economic competition with the Appointee who is the subject of the hearing.

Section 11.8. Time Frame, Postponements, and Extensions.

A hearing must occur no later than three (3) months after receipt of the request therefore, unless postponements or extensions are granted. Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested but shall be permitted only by the President/CEO if a hearing date has not yet been set, or only by the presiding officer after such has been appointed. The petitioner must make every reasonable effort to be available for the hearing dates established. Postponements and extensions of time beyond the times expressly permitted herein may be requested in writing by anyone but shall be permitted only by the Hearing Panel or its Chair acting upon its behalf on a showing of good cause. The presiding officer may adjourn the hearing and

reconvene the same at the convenience of the participants without Special Notice. A hearing shall be postponed no more than twice. Upon conclusion of the presentation of evidence, the hearing shall be closed. The hearing shall be adjourned at such time as the transcript of the proceedings is received, or upon the submission of written closing statements by the parties (as applicable), whichever is later.

SECTION 11.9. Recommendation of the Hearing Panel

Within thirty (30) days after adjournment, the Hearing Panel shall thereupon, outside of the presence of any other person except the hearing officer, if any, conduct its deliberations and prepare a written recommendation and accompanying report. The report shall contain a concise statement of the reasons justifying the recommendation made. The recommendation and report of the Hearing Panel and the petitioner's written statement shall be delivered to the Hospital President/CEO for transmittal to the Board. The Board shall not take final action until the petitioner has been deemed to have waived the right to an appeal as provided in these Bylaws. The President/CEO shall send a copy of the recommendation and report by Special Notice, to the petitioner and to the Medical Executive Committee whose recommendation gave rise to the hearing.

SECTION 11.10. Hearing Procedure

11.10.1. Personal Presence Mandatory.

Under no circumstances shall the hearing be conducted without the personal presence of the petitioner. unless the petitioner has waived such appearance or, without good cause, has failed to appear after the appropriate notice. The personal presence of the petitioner shall be required at the hearing. A petitioner who fails, without good cause, to appear and proceed at such a hearing shall be deemed to have waived his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled, and such failure to appear shall be deemed to constitute voluntary acceptance of the recommendations or actions pending. The matter shall then be referred to the Board for final decision.

11.10.2. Representation.

The petitioner, at his/her sole expense, shall be entitled to be represented at the hearing by an attorney or other person of the petitioner's choice to examine/cross-examine witnesses and present his/her case. He/She shall inform the President/CEO in writing of the name of that person not less than ten (10) days prior to the date of the hearing. The President/CEO may also appoint a person, who may be an attorney, to represent the position of the Hospital or any Medical Staff Committee or Clinical Department, and who may examine and cross-examine witnesses at the hearing. Representation by counsel shall in no way interfere with the ability of the presiding officer or Hearing Panel to hear directly from the petitioner. The hearing shall be restricted to those individuals involved in the hearing and appropriate administrative personnel as requested by the Chief of Staff, CMO and the President/CEO and agreed upon by the petitioner.

11.10.3. Record of Hearing.

A record of the hearing shall be maintained by a court reporter. The cost of such court reporter shall be borne by the Hospital. Upon request, the petitioner shall be entitled to obtain a copy of the record upon paying a reasonable charge. The record of any hearing is absolutely protected from disclosure to the greatest extent permitted by law.

11.10.4. Hearing Rights of Both Sides.

At the hearing both sides shall have the following rights: to be represented by an attorney or other person of the party's choice; to be provided with a list of witnesses and copies of documents to be relied upon by the other party at the hearing; to have a record make of the proceedings, copies of which may be obtained by the petitioner upon payment of any reasonable charges associated with the preparation thereof; to call and examine witnesses to the extent available and relevant; to introduce exhibits; to cross-examine any witness on any matter relevant to the issues; to present and/or rebut any evidence determined relevant by the presiding officer regardless of the admissibility of the evidence in a court of law; to submit a written statement at the close of the hearing; to receive, upon completion of the hearing, a copy of the written recommendation of the Hearing Panel (including a statement of the basis for the Hearing Panel's recommendation); and, to receive a copy of the written decision of the Board (including a statement of the basis for the Board's decision).

11.10.5. Admissibility/Presentation of Evidence.

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admissible if, in the judgment of the presiding officer, it is the sort of evidence on which responsible persons rely in the conduct of serious affairs. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and these memoranda shall become a part of the hearing record. The presiding officer may, but is not required to, order that oral evidence be taken only on oath or affirmation.

11.10.6. Matters Allowed to be Considered.

The Hearing Panel shall be entitled to consider any pertinent material contained on file in the Hospital and all other information that can be considered, pursuant to the Medical Staff Bylaws, in connection with applications for appointment or reappointment to the Medical Staff or for Clinical Privileges. The Hearing Panel shall be entitled to conduct independent review, research and interviews, but may use the products of this in its decision only if the parties are aware of and have the opportunity to rebut any information so gathered.

11.10.7. Deliberations and Written Statements.

The Hearing Panel may meet outside the presence of the parties to deliberate and/or establish procedures. The Hearing Panel may require that the parties submit written, detailed statements of the case to the Hearing Panel and to each other. Statements of the case may consist of a recitation of all the facts of the case. If so, the hearing can consist of clarification and explanation of the

written statements of the case. If a party is ordered by the Hearing Panel to supply a detailed statement of the case and fails to do so, the Hearing Panel can conclude that such failure constitutes a waiver of that party's case.

11.10.8. Witness Statements.

Statements from members of the Medical Staff, nursing or other Hospital staff, other professional personnel, patients or others may be distributed to the Hearing Panel and the parties in advance of or at the hearing. The statements shall be made a part of the record of the hearing and given such credence as may be appropriate. These statements must be available to all parties. When time and distance allow, the authors of the statements should be available at the hearing for questioning by either party, if so requested.

11.10.9. Official Notice.

The presiding officer shall have the discretion to take official notice of any matters either technical or scientific, relating to the issues under consideration which could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present a written rebuttal of any evidence admitted on official notice.

11.10.10. Basis of Decision.

The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

(a) oral testimony of witnesses;

(b) memorandum of points and authorities presented in connection with the hearing;

(c) any material contained in the Hospital's files regarding the petitioner so long as this material has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;

(d) any and all applications, references, and accompanying documents;

(e) all officially noticed matters;

(f) any other admissible evidence.

11.10.11. Order of Presentation.

At the hearing, the MEC or Board, as applicable, and the petitioner may make opening statements. Following the opening statements, the evidence will be presented in the following order:

(a) The body triggering the hearing shall first come forward with evidence in support of its recommendation/action.

(b) The petitioner shall then come forward with evidence in his/her support.

(c) The triggering body may then submit evidence in rebuttal to that presented by the petitioner.

(d) The triggering body may then make a closing statement.

(e) The petitioner may then make a closing statement. The petitioner's right to make a closing statement is not foreclosed if the triggering body did not elect to make a closing statement.

(f) The triggering party and the affected Appointee may submit written statements within 14 days of the close of the hearing.

11.10.12. Burden of Proof.

In order to prevail, the petitioner must establish by clear and convincing evidence that the recommendation/action that prompted the hearing was unreasonable, not sustained by the evidence, lacks substantial factual basis or otherwise unfounded, or that the conclusions drawn are arbitrary or capricious.

11.10.13. Recess and Adjournment.

The presiding officer may recess the hearing and reconvene the same for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing shall be adjourned at such time as the transcript of the proceedings is received, or upon the submission of written closing statements by the parties (if applicable), whichever is later.

11.10.14. Deliberations and Recommendations of the Hearing Officer.

Within twenty (20) days after adjournment of the hearing, the Hearing Panel shall deliberate outside the presence of any other person except the presiding officer and shall render a written report and recommendation that shall contain a concise statement of the reasons justifying the recommendation made. The hearing recommendation shall be based exclusively upon the evidence presented at the hearing.

11.10.15. Disposition of Hearing Officer Report & Recommendation.

Upon its receipt, the President/CEO shall forward the Hearing Panel's report and recommendations, along with all supporting documentation, to the body that issued the Adverse recommendation/action. Within fifteen (15) days of receiving the Hearing Panel's report and recommendation, the initiating body shall make its final recommendation and deliver it to the President/CEO, who shall deliver such to the Board (if the Board is not the initiating body) for final determination.

(a) Favorable Recommendation or Action. When the MEC's recommendation is favorable to the petitioner, the Board may adopt or reject all, or any portion, of the MEC's recommendation, or refer the matter back to the MEC for additional consideration. Any such referral shall state the reason(s) for the requested reconsideration, set a time limit within which a subsequent recommendation must be made, and may include a directive that an additional hearing be conducted to clarify issues in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take action. A favorable determination by the Board shall be effective as its final decision and the matter shall be considered closed.

(b) Adverse Recommendation or Action. If the recommendation of the MEC and/or decision of the Board is or continues to be Adverse to the petitioner after exhaustion of his/her hearing rights, the petitioner shall be entitled, upon timely and proper request, to an appellate review before a final decision is rendered on the matter by the Board.

(c) Notice of Result. The President/CEO shall provide a copy of the final recommendation of the body whose Adverse recommendation or action triggered the hearing, together with a copy of the Hearing Panel's report and recommendation to the petitioner by Special Notice, and to the Board. The Board shall also be provided with a copy of the transcript of the proceedings and exhibits. In the event of an Adverse result, the notice shall inform the petitioner of the right to request an appellate review by the Board before a final decision regarding the matter is rendered.

SECTION 11.11. Appeal.

11.11.1. Right to and Time for Appeal.

Within fifteen (15) days after the petitioner is notified by the Hospital President of an adverse recommendation from a Hearing Panel to the Hospital Board, the petitioner may request an appellate review. The request shall be in writing, shall be delivered to the Hospital President either in person or by certified mail, and shall include a brief statement of the reasons for appeal. If such appellate review is not requested within fifteen (15) days as provided herein, the petitioner shall be deemed to have accepted the recommendation involved and it shall thereupon become final and effective immediately after the Hospital Board decision.

11.11.2. Grounds for Appeal.

The grounds for appeal from an adverse recommendation shall be that:

(a) there was substantial failure on the part of the Hearing Panel to comply with the Hospital or Medical Staff Bylaws in the conduct of hearings and recommendations based upon hearings so as to deny due process or a fair hearing; or

(b) the recommendation was made arbitrarily, capriciously or with prejudice; or

(c) the recommendation of the Hearing Panel was not supported by the evidence.

11.11.3. Time Place and Notice.

Whenever an appeal is requested as set forth in the preceding sections, the Chair of the Board shall, within 10 days after receipt of such request, schedule and arrange for an appellate review. The Board shall cause the petitioner to be given notice of the time, place and date of the appellate review. The date of appellate review shall be not less than twenty (20) days, nor more than forty (40) days, from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from a petitioner who is under suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chair of the Board for good cause.

11.11.4. Nature of Appellate Review.

The Chair of the Board shall appoint a Review Panel composed of no less than three (3) Board members, at least one being a physician who is not in direct economic competition with the petitioner, and designate the Chair thereof, to consider the record upon which the recommendation before it was made. The Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross examination or confrontation provided at the Hearing Panel proceedings. Each party shall have the right to present a written statement in support of his/her position on appeal, and in its sole discretion, the Review Panel may allow each party or its representative to appeal personally and make oral argument. The review Panel shall recommend final action to the Board. The Board may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation.

11.11.5. Final Decision of the Board.

Within thirty (30) days after the conclusion of the proceedings before the Review Panel, the Board shall render a final decision, reduce it to writing, and deliver copies thereof to the petitioner and to the pertinent Medical Staff committee by Special Notice.

11.11.6. Further Review.

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

review. Provided, however, if the matter is referred by the Board for further action and recommendation, such recommendations shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process with report and recommendation shall be accomplished within thirty (30) days unless the parties otherwise stipulate.

11.11.7. Right to One Appeal Only.

No petitioner shall be entitled as a matter of right to more than one appellate review on any single matter which may be the subject of an appeal. However, nothing herein shall restrict the right of an applicant to reapply for appointment to the Medical Staff or restrict the right of an Appointee to apply for reappointment or an increase in Clinical Privileges after the expiration of two (2) years from the date of such Board decision unless the Board provides otherwise in its written decision.

SECTION 11.12. Representation by Counsel.

At such time as the petitioner, the MEC, or Board is represented by legal counsel, then all notices required to be sent herein may be served upon such party's legal counsel, and the requirement that such notices be sent by Special Notice is hereby waived; rather, such notices may be sent by regular first class U.S. mail.

SECTION 11.13. Board Action.

The procedures specified in these Bylaws shall not preclude the Board from taking any direct action authorized under the Board's bylaws, policies, and/or procedures.

ARTICLE 12.

RULES AND REGULATIONS OF THE PROFESSIONAL STAFF

The Medical Staff, with the approval of the Board, shall adopt such rules and regulations as may be necessary to implement more specifically the general principles of conduct found in these Bylaws. The Rules and Regulations shall set standards of practice that are to be required of each health care professional in the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. The Rules and Regulations shall have the same force and effect as the Bylaws.

ARTICLE 13.

FORMULATION, REVIEW, AMENDMENT, ADOPTION AND REPEAL OF BYLAWS AND MANUALS

SECTION 13.1. Medical Staff Responsibility.

The Medical Staff shall have the responsibility to review, formulate, amend, adopt, and/or repeal these Bylaws, and to recommend any such changes thereto to the Board, which changes shall be effective only when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. Neither the Board nor the Medical Staff may unilaterally amend or nullify the Medical Staff Bylaws, or other related Medical Staff governance documents. Rather, the provisions set forth in this Article shall be the sole means for creating, amending, adopting and/or repealing such documents. These Bylaws and the Rules and Regulations shall be reviewed and updated as necessary to assure congruence with Medical Staff practice and changes in standards, but at least once every three (3) years. Policies of the Medical Staff shall be supportive of, and congruent with, the Medical Staff Bylaws, Rules & Regulations.

SECTION 13.2. Methods Of Adoption, Amendment And Repeal.

Changes made to these Bylaws will affect each of the Hospitals which have separately and voluntarily adopted a single, aligned Medical Staff Bylaws document; therefore, any changes must come before the KHN Medical Staff Bylaws Alignment Committee ("Alignment Committee") for its review and recommendations prior to submission to the Hospital Board. The Alignment Committee's recommendation regarding such change(s) must be submitted to the Board along with the MEC's and/or Medical Staff's recommendation. If a Hospital's Board does not accept the recommendation submitted to it by the Alignment Committee, and such Hospital's Board takes action that is in conflict with the recommendation of the Alignment Committee, then such Board action shall automatically withdraw such Hospital from participation in the organization and governance of these aligned Bylaws. If the Alignment Committee and Hospital Board are in agreement with a change, such change shall be incorporated into these Bylaws after distribution to and approval of the other affected Hospitals in accordance with this Section. Subject to the foregoing provision of this Section, these Medical Staff Bylaws may be adopted, amended or repealed by the following actions:

13.2.1. Medical Executive Committee Action.

The MEC may make corrections and minor, non-substantive, technical changes when such correction or change is necessary due to a change in law, or due to clerical error such as spelling, punctuation, or grammar. Any correction or technical change shall be approved by the affirmative vote of two-thirds (2/3rds) of the voting MEC members and become effective immediately. No prior notice to the Medical Staff of such change is required. All corrections or changes thus made will be reported to the Hospital President/CEO and to the Medical Staff at its next scheduled general meeting.

In the event of urgent and documented need, the Bylaws may be temporarily amended by a two-thirds (2/3) affirmative vote at a regular or Special Meeting of the MEC with subsequent approval by the Board. Such temporary amendments shall be submitted to the Medical Staff at the next Annual or Special Meeting at which time they shall either be affirmed or disapproved according to the voting procedure described in these Bylaws.

13.2.2. Medical Staff Action.

The Bylaws may be adopted, amended, or repealed by the affirmative vote of two-thirds (2/3) of the voting Appointees in good standing present at a regular or Special Meeting of the Medical Staff provided that a copy of the proposed documents or amendments was provided to each voting Appointee not less than twenty-one (21) days in advance of the meeting and provided that each voting Appointee was notified that such matter would come to vote at the meeting. Absentee ballots are permitted.

13.2.3. Board Action.

Adoption, amendment, or repeal of the Medical Staff Bylaws shall require the affirmative vote of the Board. If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. The President/CEO will schedule such conference within fourteen (14) days after receipt of a request for a conference from the Chief of Staff. The Board may then take final action.

SECTION 13.3. Related Medical Staff Governance Documents.

MEC may develop and amend Manuals and Medical Staff policies provided that such documents are approved by a two-third (2/3) vote of the voting members of the MEC. The development and amendment of such Manuals and Medical Staff policies will not require the approval of the active Medical Staff. Such Manuals and Medical Staff policies must be consistent with the Bylaws. Any such Manual or Medical Staff policy, or amendments thereto, shall not become effective until approved by the Board. The Medical Staff will be notified of any such documents or amendments by a reasonable means of delivery including, but not limited to, by mail, fax or electronic transmission; and such documents will be available in the Medical Staff Services Department for review. A current copy of the Bylaws, Organization and Functions Manual, and, Credentials Policy Manual will be made available to allow Practitioners to attest to reading and abiding by them at the time of appointment, reappointment, and/or granting Privileges.

SECTION 13.4. Board Action

13.4.1. Conflict with MEC/Medical Staff Recommendation.

If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. The President/CEO will schedule such conference within fourteen (14) days after receipt of a request for a conference from the Chief of Staff. The Board may then take final action.

13.4.2. Board-Initiated Action.

In the event the Medical Staff or the MEC, as applicable, fails to exercise its responsibility in good faith and in a reasonable and timely manner, and after written notice from the Board to such effect including a reasonable time for response, the Board may take action pursuant to these Bylaws. Should the Medical Staff/MEC fail to respond under such circumstances or should the Board disagree with any responses or recommendations from the Medical Staff/MEC for adoption, amendment or repeal of any of the Medical Staff Bylaws, Rules and Regulations, or Medical Staff policies, the Board's recommendation shall be referred to the JCC for consideration of the recommendations of the Board and the Medical Staff/MEC regarding such proposed adoption, amendment or repeal prior to final action by the Board.

The JCC shall make a recommendation to the Board within thirty (30) days of receipt of the proposed adoption, amendment or repeal of, as applicable, the Bylaws, Rules and Regulations, or Medical Staff policies. At its next regularly scheduled meeting after receipt of a recommendation from the JCC, the Board shall take final action with respect to the adoption, amendment or repeal under consideration. Such action by the Board may include ratifying or modifying, in whole or in a part, the recommendation of the JCC to remain in compliance with law and accreditation and certification requirements. Should there be a tie among the JCC members with respect to the issues being considered, the Board Chair shall be called upon to cast a vote on the issue under consideration. The recommendation of the JCC shall be forwarded to the Board for final action.

13.4.3. Conflict within Documents.

In the event of a conflict between the Hospital's code of regulations or a Hospital policy and the Medical Staff Bylaws, the Hospital's code of regulations or policy, as applicable shall control. If there is a conflict between the Medical Staff Bylaws and a Manual or Medical Staff policy, the Bylaws shall control. Such conflict shall then be reviewed by the MEC to determine how such conflict can be resolved.

SECTION 13.5. Appointee Action.

To the extent that a Manual provision or Medical Staff policy is not required by federal or state law or regulations, accrediting or certification standards, Medicare Conditions of Participation, or

third party payors, any active Appointee in Good Standing may raise a reasonable challenge made in good faith to any Manual provision(s) or Medical Staff policy established by the MEC and approved by the Board. In order to raise such challenge, the active Appointee must submit to the MEC a petition signed by not less than ten percent (10%) of the voting Appointees in Good Standing. Upon receipt of the petition, the MEC shall either (a) provide the petitioner(s) with information clarifying the intent of such Manual provision(s) or Medical Staff policy; and/or (b) schedule a meeting with the petitioner(s) to discuss the issue. In the event that the issue cannot be resolved to the satisfaction of the petitioner(s), the matter shall be brought before the Medical Staff for vote and forwarded to the Board for final action.

NOTE: The Appointee is responsible for researching relevant federal and state law and regulations, accrediting and certification standards, Medicare Conditions of Participation, and third party payors' requirements, and is able to assert in good faith, citing to such relevant research that he or she believes that the provision or policy being challenged is not required under any such law, regulations, standards, or conditions.

SECTION 13.6. Adoption of These Bylaws By A New Hospital.

When a KHN Hospital that is not a part of the original Hospitals which are adopting and effectuating this aligned Medical Staff Bylaws document, adopts and effectuates these Bylaws "as is" without changes, and likewise adopts the corresponding governing documents, Rules and Regulations, then the amendment process is not triggered; and the Alignment Committee may add the fully executed "Certification of Adoption and Approval" page to these Bylaws, as well as the name of such Hospital to the cover pages of the relevant documents, and the name of such Hospital to the footnote of the Preamble of these Bylaws. The Chair of the Alignment Committee will then notify all other KHN Hospital Medical Staffs of such addition via the Medical Staff newsletter, KN webpage, or any other reasonable means.

SECTION 13.7. Miscellaneous.

If significant changes are made to any of the Medical Staff governing documents, Appointees of the Medical Staff and other individuals who have Privileges shall be provided access to a print or electronic text of the revised materials.

ARTICLE 14.

CONFIDENTIALITY, IMMUNITY AND RELEASE

SECTION 14.1. Special Definitions.

For purposes of this Article, the following definitions shall apply:

- INFORMATION means record of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearing, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications whether in written or oral form relating to any of the subject matter specified in §14.5 of this Article.

- REPRESENTATIVE means the Board and any director or committee thereof; the President/CEO or the President/CEO's designee; registered nurses and other employees of the Hospital; the Medical Staff organization and any Appointee, officer, Clinical Department or Section, or committee thereof; any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.

- THIRD PARTIES means any individual or organization providing information to any Representative.

SECTION 14.2. Authorizations And Releases.

Each Practitioner shall, upon request of the Hospital, execute general and specific releases and authorizations in accordance with the tenor and import of this Article, subject to such requirements as may be applicable under the State of Ohio and federal law. Execution of such releases and authorizations is not a prerequisite to the effectiveness of this Article. Such releases and authorizations will operate in addition to the provisions of this Article.

By submitting an application for Medical Staff appointment or reappointment or by applying for or exercising privileges or scope of services at the Hospital, a Practitioner:

(a) Authorizes Representatives to solicit, provide and act upon information bearing on his or her professional ability and other qualifications.

(b) Agrees to be bound by the provisions of the Article and to waive any and all legal claims against any Representative who acts in accordance with the provisions of this Article.

(c) Acknowledges that the provisions of this Article are express conditions to his/her application for, or acceptance of, Medical Staff appointment and the continuation

of such appointment, and to his/her exercise of Privileges or provisions or specified patient care services at the Hospital.

SECTION 14.3. Confidentiality Of Information.

Information with respect to any Practitioner submitted, collected or prepared by any Representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, monitoring or improving the quality, appropriateness and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, or determining that health care services are professionally indicated or were performed in compliance with the applicable standards of care or establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential. Said information shall not be disseminated to anyone other than a representative or other health care facility or organization of health professionals engaged in an official, authorized activity for which the information is needed, or be used in any way except as provided herein, or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided to third parties. This information shall not become part of any particular patient's record. It is expressly acknowledged by each Practitioner that violation of the confidentiality provided herein is grounds for immediate and permanent revocation of Medical Staff appointment and Privileges or specified services.

SECTION 14.4. Immunity From Liability

14.4.1. For Action Taken.

After reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the decision, opinion, action, statement, or recommendation is warranted by such facts, then a Representative of the Hospital or Medical Staff shall not be liable to a Practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his or her duties as a Representative, unless such Representative acts on the basis of false information knowing it to be false.

14.4.2. For Providing Such Information.

No Representative of the Hospital or Medical Staff and no Third Party shall be liable to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff or to any other health care facility or organization of health professionals concerning a Practitioner who is or has been an Applicant to or Appointee of the Medical Staff or who did or does exercise Clinical Privileges or provide specified services at this Hospital, provided that such Representative or Third Party does not act on the basis of false information knowing it to be false, and provided further that such information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

SECTION 14.5. Activities And Information Covered

14.5.1. Activities.

The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

(a) Applications for appointment, privileges, or specific services.

(b) Periodic reappraisals for reappointment, privileges or specific services.

(c) Corrective actions, recommended or taken.

(d) Hearings and appellate reviews.

(e) Performance improvement/quality assessment activities.

(f) Utilization review activities.

(g) Claims reviews.

(h) Profiles and profile analysis.

(i) Risk management activities.

(j) Other Hospital, committee, Clinical Department/Section, or Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

14.5.2. Information.

The information referred to in this Article may relate to a Practitioner's professional licensure or certification, education, training, clinical competency, judgment, utilization practices, character, ability to fully and competently carry out the privileges requested, professional ethics, or any other matter that might directly or indirectly affect the quality, efficiency, or appropriateness of patient care provided in the Hospital.

SECTION 14.6. Cumulative Effect

Provisions in these Medical Staff Bylaws and in application forms relating to authorization, confidentiality of information, and immunities from liability are in addition to other protections provided by state and federal law and not in limitation thereof.

ARTICLE 15.

INDEMNIFICATION OF OFFICERS, CHAIRS AND MEMBERS

To the fullest extent permitted by the laws of the State of Ohio, the Hospital shall indemnify and hold harmless all Medical Staff officers, committee chairpersons and Members who perform, in good faith and without malice, functioning as agents of the Hospital, from and against any monetary settlements made or judgments rendered against such persons; provided, however, that such indemnification shall not extend to any claims or legal proceedings made or brought against such persons which arise out of such person's acts outside the scope of the agency or which are committed in bad faith or with malice.

CERTIFICATION OF ADOPTION AND APPROVAL

These Bylaws are adopted and made effective upon approval of the Board in accordance with any Board stipulations, superseding and replacing any and all other Medical Staff Bylaws, Rules & Regulations, policies, or Manuals pertaining to the subject matter thereof.

Adopted by the Medical Executive Committee of Kettering Medical Center System on November 16, 2021

Gary Anderson, DO
Chief of Staff

Adopted by the Medical Staff of Kettering Medical Center System on November 16, 2021

Approved and adopted by the Board of Directors, specifically subject to being made effective at such time as the Manuals, Rules and Regulations, and relevant Medical Staff policies are amended in accordance with the terms of these Bylaws, on February 3, 2022

Sharlet Briggs, PhD
Secretary, Board of Directors