THE NEBRASKA MEDICAL CENTER
MEDICAL STAFF GOVERNANCE POLICY

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MEDICAL STAFF GOVERNANCE

TABLE OF CONTENTS

PAGE

ARTICLE 1

GENERAL

1.A. Definitions:

The following definitions shall apply to terms used in the Governance and related policies and manuals:

(1) "Allied Health Professionals" means individuals other than Appointees who are authorized by law to provide patient care services, whose scope of practice is defined in the Policy on Allied Health Professionals.

(2) "Appointee" means any physician, dentist, or oral surgeon who has been granted Medical Staff appointment by the Board to practice at the Hospital.

(3) "Board" means the Board of Directors of The Nebraska Medical Center, which has the overall responsibility for the Hospital, or its designated committee.

(4) "Board Certification" is the designation conferred by: (i) one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), (ii) the American Osteopathic Association ("AOA"), (iii) the American Board of Oral and Maxillofacial Surgery, (iv) boards recognized by the American Dental Association, or (v) a board of another country recognized by the Medical Staff Executive Committee, upon a physician or dentist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

(5) "CCPPA" means the Chair of Clarkson Private Practice Affairs.

(6) "Chief Executive Officer" ("CEO") means the individual elected by the Board as president.

(7) "Chief Medical Officer" ("CMO") means the individual appointed by the CEO to act as the chief medical officer of the Hospital pursuant to a general authorization by the Board.

(8) "Chief Nursing Officer" ("CNO") means the individual appointed by the CEO to act as the Chief Nursing Officer of the Hospital pursuant to a general authorization by the Board.

(9) "Clinical Privileges" means the authorization granted by the Board to render specific patient care services.

(10) "Credentials Policy" means the Hospital's Medical Staff Credentials Policy.

(11) “Days” means calendar days.

(12) “Dentist” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).

(13) “Full-Time Academic Faculty Category.” The Full-time Academic Faculty Category of the Active Staff shall be comprised of those Medical Staff Appointees who spend more than 25% of their time as academic faculty but are not in full-time private practice.

(14) “Hospital” means a hospital that is part of The Nebraska Medical Center.

(15) “Hospital Based Services” shall mean radiology and nuclear medicine, pathology, radiation-oncology and anesthesiology.

(16) “Medical Staff” means all physicians, dentists and oral and maxillofacial surgeons who have been appointed to the Medical Staff by the Board.

(17) “Medical Staff Executive Committee” means the Executive Committee of the Medical Staff.

(18) “Medical Staff Officer” shall be the Chief of Staff, Vice Chief of Staff and Secretary-Treasurer of the organized Medical Staff.

(19) “Non-Hospital Based Services” means all Services which are not Hospital Based Services.

(20) “Notice” means written communication by regular U.S. mail, e-mail, certified mail, facsimile, or Hospital mail, overnight delivery or hand delivery.

(21) “Policy” shall mean those documents, subsidiary to this document, adopted by the Medical Staff Executive Committee and the Board with respect to conduct of the Medical Staff affairs.

(22) “Physician” includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).

(23) “Private Practice Category” The Private Practice Category of the Active Staff shall be comprised of those Medical Staff Appointees who spend more than 25% of their professional activity at The Nebraska Medical Center and are not full-time academic physicians.

(24) “Service” shall mean those services established in the Policy on Organization and Functions.

(25) "Unassigned Patient" means any individual who comes to the Hospital for care or treatment and who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him or her care while a patient at the Hospital.

1.B. Time Limits:

Time limits referred to in the Governance Policy 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.

1.C. Delegation of Functions:

When a function is to be carried out by a person or committee, the person, or the committee through its chair, may delegate performance of the function to one or more designees.

1.D. Medical Staff Dues:

(1) Annual Medical Staff dues shall be as established by the Medical Staff Executive Committee and may vary by category.

(2) Dues will be assessed in January of each year. Those individuals who have not paid their dues by April 15th shall be considered to have voluntarily resigned from the Medical Staff, after which time, an individual will be treated as a new applicant. New applicants whose applications are received prior to June 30 shall be assessed Medical Staff dues for the entire year, while those whose applications are received subsequent to June 30, shall have dues prorated for the current year.

1.E. Medical Staff Account:

The Medical Staff shall have a bank account or accounts which shall have as signatories, such individuals as the Medical Staff Executive Committee shall determine, but who as a minimum shall include the Chief of Staff and the Secretary-Treasurer.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentials Policy are eligible to apply for appointment to one of the categories in Sections 2.A, 2.B and 2.C hereof:

2.A. Active Staff:

(1) Qualifications:

(a) The Active Staff shall consist of those physicians and dentists who attend, admit, and use The Nebraska Medical Center as their primary hospital for a minimum of 25% of their professional activity or are Academic Faculty of the University Of Nebraska College Of Medicine. Involvement in the treatment of patients shall include consultations and outpatient surgical or diagnostic procedures.

(b) Once qualified as a member of the Active Staff in subparagraph (a) above, a member may continue to qualify by either being a member under either Private Practice Category or Academic Category.

(2) Prerogatives:

Active Staff Appointees shall be entitled to vote, hold office, serve on Medical Staff committees, and serve as chairpersons of such committees.

(3) Responsibilities:

Active Staff Appointees must:

(a) assume all the responsibilities of membership on the Active Staff, including committee service, emergency call, care for Unassigned Patients and evaluation of Appointees during the provisional period;

(b) actively participate in the peer review and performance improvement process;

(c) accept consultations where applicable;

(d) attend applicable meetings;

(e) pay application fees, dues and assessments; and

(f) perform assigned duties.

2.B. Consulting Staff:

(1) Qualifications:

The Consulting Staff shall consist of physicians and dentists who center a portion of their hospital work at The Nebraska Medical Center or who staff clinics operated by the medical center. They must be on the active staff at another hospital in order to be considered for the Consulting Staff at The Nebraska

Medical Center and remain in such status as a condition of continuing on the Consulting Staff. Physicians who staff The Nebraska Medical Center clinics shall be credentialed for procedures within their respective areas of expertise depending on the capability of the clinic. At the time of initial appointment and at each reappointment time, Consulting Staff Appointees must provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and Clinical Privileges.

(2) Prerogatives and Responsibilities:

Consulting Staff Appointees:

(a) may serve on committees by appointment (with vote) and may attend meetings of the Medical Staff and applicable service meetings (without vote);

(b) may not hold office or serve as Service chiefs or committee chairs; and

(c) shall pay application fees, dues and assessments.

2.C. Emeritus Staff:

Medical Staff Appointees who have attained the age of 70 years shall automatically advance at that time to the Emeritus Staff and shall undergo annual review of their privileges and credentialing and staff appointment. Emeritus Staff Appointees may participate in staff activities as assigned by a Service chief or the Chief of Staff. Emeritus Staff Appointees or those who have attained the age of 70 years who continue to admit and care for patients shall have the same privileges and responsibilities that they had previously, including the right to vote and hold office, if applicable, but shall not be responsible for paying dues.

2.D. Courtesy Staff Without Privileges:

The Courtesy Staff without Privileges Category shall consist of physicians and dentists who wish to be associated with The Nebraska Medical Center. Courtesy Staff will not be required to possess Medical Malpractice Insurance to maintain Medical Staff appointment. Courtesy Staff Appointees shall not be granted Clinical Privileges, be eligible to serve on committees, vote at Medical Staff meetings. Courtesy Staff will be responsible for paying dues.

2.E. Honorary Staff:

The Honorary Staff shall consist of Medical Staff Appointees who have retired from active Hospital practice or other physicians or dentists who are of outstanding reputation, not necessarily residing in the community. Honorary Staff Appointees shall not be

eligible to admit or attend patients, to vote, to hold office, or to serve on standing Medical Staff committees, but may be appointed to special committees. Honorary Staff Appointees shall not be responsible for paying dues.

ARTICLE 3

OFFICERS

3.A. Designation:

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff and Secretary-Treasurer.

3.B. Eligibility Criteria:

Only those Appointees to the Active Staff who satisfy the following criteria initially (and where applicable continuously) shall be eligible to serve as an officer of the Medical Staff. They must:

(1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least two years;

(2) have no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges;

(3) not presently be serving as a Medical Staff officer, Board appointee or Service chief at any non-federal hospital and shall not so serve during their term of office;

(4) be willing to faithfully discharge the duties and responsibilities of the position;

(5) have experience in a Medical Staff or other leadership position, or involvement in performance improvement functions for at least two years;

(6) attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;

(7) have demonstrated an ability to work well with others; and

(8) not have a conflict of interest which is not fully disclosed to the Chief of Staff and Medical Staff Executive Committee or to fully disclose an employment relationship with an institutional provider of health care services, which is in competition with the Hospital.

The Medical Staff Executive Committee will determine conflict of interest by a two-thirds majority vote.

3.C. Duties:

(1) Chief of Staff:

The Chief of Staff shall:

(a) interface with the Dean of the College of Medicine, Chief Executive Officer, CMO, CNO, CCPPA, Board, Hospital risk manager, Hospital attorney and other Hospital employees or consultants as needed;

(b) act in coordination and cooperation with Hospital management in matters of mutual concern involving the care of patients in the Hospital;

(c) represent and communicate the views, policies and needs of, and report on the activities of, the Medical Staff to the Medical Staff Executive Committee, Dean of the College of Medicine, Chief Executive Officer, CMO, CCPPA and the Board;

(d) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Medical Staff Executive Committee;

(e) observe and document the clinical performance of the Medical Staff and communicate his or her assessment to the Board, Chief Executive Officer, CMO, Dean of the College of Medicine and CCPPA;

(f) appoint all Medical Staff committee chairs and Medical Staff committee members, in consultation with the Medical Staff Executive Committee;

(g) chair the Medical Staff Executive Committee (with vote, as necessary) and be an ex officio member of all other Medical Staff committees;

(h) promote adherence to this Governance Policy, Rules and Regulations of the Medical Staff and to the Policies and Procedures of the Hospital;

(i) recommend Medical Staff representatives to Hospital committees;

(j) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy;

(k) facilitate research and educational activities of the College of Medicine in Nebraska Medical Center; and

(l) have the power to appoint an acting Chief of Staff to act in his or her absence or unavailability, if the Vice Chief is not available.

(2) Vice Chief of Staff:

The Vice Chief of Staff shall:

(a) assume all duties of the Chief of Staff and act with full authority as Chief of Staff in his or her absence;

(b) serve as liaison to the Physician Quality Committee;

(c) serve on the Medical Staff Executive Committee; and Vote

(d) assume all such additional duties as are assigned to him or her by the Chief of Staff or the Medical Staff Executive Committee.

(3) Secretary-Treasurer:

The Secretary-Treasurer shall:

(a) be responsible for providing notices as specified in this Governance Policy;

(b) serve on the Medical Staff Executive Committee; and

(c) be responsible for the collection of, accounting for, and disbursements of any funds collected, donated, or otherwise assessed and present in the Medical Staff Fund and report to the Medical Staff.

3.D. Election:

The officers of the Medical Staff shall be selected from the membership of the Medical Staff Executive Committee. The election of each officer shall become effective as soon as approved by the Board.

3.E. Term of Office:

Officers shall serve for a term of two years or until a successor is elected.

3.F. Removal:

(1) Removal of an elected officer may be effectuated by a two-thirds vote of the Medical Staff Executive Committee, or by the Board, for:

(a) failure to comply with applicable Policies, Governance, or Rules and Regulations;

(b) failure to perform the duties of the position held;

(c) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(d) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Medical Staff Executive Committee or the Board prior to a vote on removal.

3.G. Vacancies:

A vacancy in the office of Chief of Staff shall be filled by the Vice Chief Of Staff, who shall serve until the end of the Chief of Staff unexpired term. In the event there is a vacancy in another office, the Medical Staff Executive Committee shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, in the discretion of the Medical Staff Executive Committee.

ARTICLE 4

STAFF SERVICES

4.A. Organization:

The Medical Staff shall be organized into the Services as listed in the Policy on Organization and Functions. Subject to the approval of the Board, the Medical Staff Executive Committee may create new Services, eliminate Services, create divisions within Services, or otherwise reorganize the Service structure.

4.B. Assignment to Service:

(1) Upon initial appointment to the Medical Staff, each Appointee shall be assigned to a clinical Service. Assignment to a particular Service does not preclude an individual from seeking and being granted Clinical Privileges typically associated with another Service.

(2) An individual may request a change in Service assignment to reflect a change in the individual's clinical practice.

4.C. Functions of Services:

The Services shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the Services, and (ii) to monitor the practice of all those with Clinical Privileges in a given Service. Each Service shall assure emergency call coverage for all patients.

4.D. Qualifications of Service Chiefs:

Each Service chief shall:

(1) be an Active Staff Appointee;

(2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and

(3) satisfy the eligibility criteria in Section 3.B.

4.E. Appointment and Removal of Service Chiefs:

(1) Non-Hospital Based Service Chiefs:

(a) Except as provided in this Article 4, Section 4.E(3), the Non-Hospital Based Service chief accountable for a Service shall be an Active Staff Appointee of the Private Practice Category who possesses the qualifications set forth in Article 4, Section 4.D, of this Governance Policy. The term, given satisfactory performance, of office will be two years. Consecutive terms may be served.

(b) The Medical Staff Executive Committee members representing the Private Practice Category shall oversee the nomination of candidates for Non-Hospital Based Service chiefs and assistant Service chief. Additional nominations to this post may be submitted by the Private Practice Category of the Active Staff Appointees from the appropriate Hospital Service. These names shall be submitted in writing to this committee through the Medical Staff Office at least five business days before the election. These names will be presented by ballot to all Active Staff Appointees of the appropriate Hospital Service, both private practitioners and Full-time Academic Faculty Active Staff Appointee. If no Appointee achieves a majority on the first ballot of those voting, the top two candidates will be voted upon in a runoff election.

(c) In the event that there are no Private Practice Active Staff Appointees who are willing or able to serve as Service chief, then the Service chief shall be selected by the Academic Department Chair and approved by the Medical Staff Officers.

(d) The election of each Non-Hospital Based Service chief and assistant Service chief must be ratified by the Medical Staff Executive Committee. The functions of the assistant Service chief shall be to act as Service chief in the absence of the Service chief and as delegated by the Service chief.

(2) Hospital-Based Service Chiefs:

(a) A Hospital-Based Service chief shall be an Active Staff Appointee who possesses the qualifications set forth in Section 3.B of this Governance Policy.

(b) A Hospital-Based Service chief for each of the Hospital-Based Services will be selected by the Chief Executive Officer and the Academic Department Chair and if no agreement on such selection is reached, by the Dean of the College of Medicine and the Chief Executive Officer. The Service chief shall work in partnership with the Academic Department Chair to achieve the mission, goals and vision statement of Nebraska Medical Center in relationship to Hospital Services. Hospital-Based Service chiefs shall serve two-year terms, and the position of Service chief will sequentially be held between Full-time Academic Faculty Category of the Medical Staff and the Private Practice Category of the Active Staff of Physicians, provided private practice physicians are Active Staff Appointees within that specialty. A Service may propose and implement a substitute arrangement to this provision, upon approval of the Medical Staff Executive Committee.

(3) Removal of Service Chiefs:

(a) Removal of a Non-Hospital Based Service chief may be effectuated by a two-thirds vote of the Service members; or by a two-thirds vote of the Medical Staff Executive Committee subject to Board confirmation; or by the Board, after reasonable notice and opportunity to be heard. Grounds for removal shall be:

(i) failure to comply with applicable Policies, Governance, or Rules and Regulations;

(ii) failure to perform the duties of the position held;

(iii) conduct detrimental to the interests of the Hospital or its Medical Staff; or

(iv) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(b) Prior to the initiation of a removal action for a Non-Hospital Based Service chief, the individual shall be given written notice of the date of the meeting at which such action shall be taken at least 10 days prior to the date of the meeting. The individual shall be afforded an opportunity to

speak to the service or Medical Staff Executive Committee or the Board, as applicable, prior to a vote on such removal.

(c) Removal of a Hospital-Based Service chief during a term of office shall be effectuated by mutual agreement between the Chief Executive Officer and the Academic Chair of the relevant department, or by the Board on its own motion. In the event that the Academic Chair is the Hospital-Based Service chief, removal shall be carried out by mutual agreement between the Chief Executive Officer and the Dean of the College of Medicine, or by the Board on its own motion. Active Staff Appointees in the Hospital Service may petition the Chief Executive Officer and the Academic Department Chair for removal of a Hospital-Based Service chief.

4.F. Duties of Service Chiefs:

Each Service chief is accountable for the following:

(1) all clinically related activities of the Service;

(2) all administratively related activities of the Service, unless otherwise provided for by the Hospital;

(3) continuing surveillance of the professional performance of all individuals in the Service who have delineated Clinical Privileges;

(4) recommending criteria for Clinical Privileges that are relevant to the care provided in the Service;

(5) evaluating requests for Clinical Privileges for each member of the Service;

(6) assessing and recommending off-site sources for needed patient care Services not provided by the Service or the Hospital;

(7) the integration of the Service into the primary functions of the Hospital;

(8) the coordination and integration of interservice and intraservice Services;

(9) the development and implementation of policies and procedures that guide and support the provision of Services;

(10) recommendations for a sufficient number of qualified and competent persons to provide care or service;

(11) determination of the qualifications and competence of Service personnel who provide patient care services;

(12) continuous assessment and improvement of the quality of care and services provided;

(13) maintenance of quality monitoring programs, as appropriate;

(14) the orientation and continuing education of all persons in the Service;

(15) recommendations for space and other resources needed by the Service;

(16) performing all functions authorized in the Credentials Policy including collegial intervention; and

(17) appointing one or more division chiefs as deemed necessary, subject to approval of the Medical Staff Executive Committee.

4.G. Divisions:

(1) Functions of Divisions:

(a) Divisions may perform any of the following activities:

(i) continuing education;

(ii) discussion of policy;

(iii) discussion of equipment needs;

(iv) development of recommendations to the Service chief or the Medical Staff Executive Committee;

(v) participation in the development of criteria for Clinical Privileges (when requested by the Service chief); and

(vi) discussion of a specific issue at the special request of a Service chief or the Medical Staff Executive Committee.

(2) Qualifications and Appointment of Division Chiefs:

Division chiefs shall meet the same qualifications, and shall be nominated by the Active Staff Appointees in the division. The election of a division chief shall be effective upon approval by the Medical Staff Executive Committee, and initial appointment shall be for a period of two years. Removal of a division chief may be initiated by a two-thirds vote of all Active Staff Appointees in the division, or by the Medical Staff Executive Committee on its own motion. Removal shall be effective upon approval of the Medical Staff Executive Committee.

(3) Duties of Division Chiefs:

The division chief shall carry out the duties requested by the Service chief. These duties may include:

(a) reviewing and reporting on applications for initial appointment and Clinical Privileges, including interviewing applicants;

(b) reviewing and reporting on applications for reappointment and renewal of Clinical Privileges;

(c) evaluation of individuals during the provisional period;

(d) participation in the development of criteria for Clinical Privileges;

(e) reviewing and reporting on the professional performance of individuals practicing within the division; and

(f) delegation to an appropriate individual within the division certain tasks, including, but not limited to, the review of applications for appointment, reappointment, or Clinical Privileges or questions that may arise if the division chief has a conflict of interest with the individual under review.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. Medical Staff Executive Committee:

(1) Composition:

(a) There shall be a single Nebraska Medical Staff Medical Staff Executive Committee which shall be composed of five Full-time Academic Category of the Medical Staff appointed by University Medical Associates, and five from Private Practice Category of the Active Staff, appointed by the Private Practice Executive Council. The Medical Staff officers are elected from the current Medical Staff Executive Committee membership.

(b) The Chief of Staff will chair the Medical Staff Executive Committee.

(c) The Chief Executive Officer, Dean of the College of Medicine, CMO, Chief Nursing Officer, and Chair of the Physician Quality Committee shall be ex officio members of the Medical Staff Executive Committee, without vote.

(d) The Chairperson of the Board may attend Medical Staff Executive Committee meetings and participate in its discussions.

(2) Duties:

The Medical Staff Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with Clinical Privileges. The Medical Staff Executive Committee shall consult with the CMO, CEO and other employees of the Hospital as appropriate. The Medical Staff Executive Committee is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Medical Staff Executive Committee meetings);

(b) recommending directly to the Board on at least the following:

(i) the Medical Staff's structure;

(ii) the mechanism used to review credentials and to delineate individual Clinical Privileges;

(iii) recommendations of individuals for Medical Staff appointment;

(iv) recommendations for delineated Clinical Privileges for each eligible individual;

(v) participation of the Medical Staff in Hospital performance improvement activities;

(vi) the mechanism by which Medical Staff appointment may be terminated; and

(vii) hearing procedures.

(c) consulting with the CMO and CEO as appropriate on quality related aspects of contracts for patient care services with entities outside the Hospital;

(d) receiving and acting on reports and recommendations from Medical Staff committees, Services, and other groups as appropriate;

(e) reviewing, at least every five years, the Governance Policy, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable; and

(f) performing such other functions as are assigned to it by this Governance Policy or other applicable Policies.

(3) Meetings:

(a) The Medical Staff Executive Committee shall meet as often as necessary to fulfill its responsibilities and maintain a permanent record of its proceedings and actions.

(b) Between meetings of the Medical Staff Executive Committee, an ad hoc committee composed of the Medical Staff officers and the credentials committee chair shall be empowered to act in situations of urgent or confidential concern where not prohibited by this Governance Policy and subject to review, ratification and approval by the Medical Staff Executive Committee at its next meeting.

5.B. Performance Improvement Functions:

(1) The performance improvement functions are the way the Medical Staff works to improve the clinical and non-clinical processes that require Medical Staff leadership or participation. These functions shall be performed by such committees, Services and individuals as may be designated by the Medical Staff Executive Committee in consultation with the Chief Executive Officer. When the performance of a process is dependent primarily on the activities of individuals with Clinical Privileges, the Medical Staff shall provide leadership for and participate in process measurement, assessment, and improvement, including, but not limited to:

(a) medical assessment and treatment of patients;

(b) use of medications;

(c) use of blood and blood components;

(d) use of operative and other procedures;

(e) efficiency of clinical practice patterns; and

(f) significant departures from established patterns of clinical practice.

(2) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Policy on Medical Staff Organization and Functions.

5.C. Patient Care Process Improvement Functions:

The Medical Staff shall also participate in the measurement, assessment, and improvement of other patient care processes. These include, though are not limited to:

(1) education of patients and families;

(2) coordination of care with other practitioners and Hospital personnel, as relevant to the care of an individual patient; and

(3) accurate, timely, and legible completion of patients' medical records.

5.D. Credentialing and Peer Review Functions:

Mechanisms for appointment, reappointment, delineation of Clinical Privileges, collegial and educational efforts, investigations, hearings and appeals that apply to Medical Staff Appointees shall be contained in the Credentials Policy.

5.E. Responsibilities and Related Documents:

Medical Staff Appointees shall fulfill all applicable responsibilities contained in this Governance Policy, Credentials Policy, Policy on Medical Staff Organization and Functions, Medical Staff Rules and Regulations and other applicable Policies and Rules and Regulations and abide by same when performing all responsibilities.

5.F. Appointment of Medical Staff Committee Chairs and Members:

(1) All Medical Staff committee chairs and members shall be appointed by the Chief of Staff, in consultation with the Medical Staff Executive Committee. Medical Staff committee chairs shall be selected based on the criteria set forth in Section 3.B of this Governance Policy.

(2) Medical Staff committee chairs and members shall be appointed for initial terms of one year, but may be reappointed for additional terms.

(3) The Chief of Staff and the Chief Executive Officer (or their respective designees) shall be members, ex officio, without vote, on all committees.

5.G. Creation of Standing Committees:

In accordance with the Policy on Medical Staff Organization and Functions, the Medical Staff Executive Committee may, by resolution and upon approval of the Board, establish additional committees to perform one or more Medical Staff functions. In the same manner, the Medical Staff Executive Committee may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by this Governance Policy which are not assigned

to an individual, a standing committee, or a special task force shall be performed by the Medical Staff Executive Committee.

5.H. Special Task Forces:

Special task forces shall be created and their members and chairs shall be appointed by the Chief of Staff. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the Medical Staff Executive Committee.

ARTICLE 6

MEETINGS

6.A. Medical Staff Year:

The Medical Staff year is January 1 to December 31.

6.B. Medical Staff Meetings:

(1) Regular Meetings:

The Medical Staff shall meet at least once a year.

(2) Special Meetings:

Special meetings of the Medical Staff may be called by the Chief of Staff, the Medical Staff Executive Committee, the Board, or by a petition signed by not less than one-fourth of the Active Staff Appointees.

6.C. Service and Committee Meetings:

(1) Regular Meetings:

Except as otherwise provided in this Governance Policy or in the Policy on Medical Staff Organization And Functions Manual, each Service, division and committee shall meet at least quarterly, at times set by the Chief or Chair.

(2) Special Meetings:

A special meeting of any Service or committee may be called by or at the request of the Chief or Chair, the Chief of Staff, or by a petition signed by not less than one-fourth of the Active Staff Appointees of the Service, division, or committee, but not by fewer than two members.

6.D. Provisions Common to All Meetings:

(1) Notice of Meetings:

(a) Medical Staff Appointees shall be provided notice of all regular meetings of the Medical Staff and regular meetings of Services, divisions, and committees at least two weeks in advance of the meetings. Notice may be provided by posting in a designated location at least two weeks prior to the meetings. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a Service and/or a committee is called, all of the provisions in paragraph (a) shall apply except that the notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). Posting shall not be the sole mechanism used for providing notice, and notice shall be given by a method or methods designed to communicate the occurrence of a meeting, e.g. hand delivered notice, e-mail notice or notice by U.S. Mail.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

(2) Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, Service, division, or committee, except the Medical Staff Executive Committee, 10% of the voting members shall constitute a quorum. For meetings of the Medical Staff Executive Committee, the presence of at least 50% of the total Committee shall constitute a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding.

(b) Recommendations and actions of the Medical Staff, Services, divisions, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present.

(c) Any matter may be presented by notice and votes returned to the Chair or Chief by the method designated in the notice. A quorum shall be the number of ballots returned. The question raised shall be determined in the affirmative if a majority of the ballots returned have so indicated.

(d) Meetings may be conducted by telephone conference.

(3) Agenda:

The Chair or Chief for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, Service, division, or committee.

(4) Rules of Order:

The latest edition of Robert's Rules of Order Revised may be used for reference at all meetings and elections, but shall not be binding. Specific provisions of this Governance Policy, and Medical Staff, Service, or committee custom shall prevail at all meetings, and the Service chief or committee chair shall have the authority to rule definitively on all matters of procedure.

(5) Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, Services, divisions and committees (and applicable division meetings) shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.

(b) A summary of all recommendations and actions of the Medical Staff, Services, divisions, and committees shall be transmitted to the Medical Staff Executive Committee and Chief Executive Officer. The Board shall be kept apprised of the recommendations of the Medical Staff and its Services, divisions, and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

(6) Confidentiality:

Medical Staff Appointees who have access to credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes. A breach of confidentiality may result in the imposition of disciplinary action.

(7) Attendance Requirements:

(a) Each Active Staff Appointee is expected to attend and participate in all Medical Staff meetings and applicable Service, division, and committee meetings each year.

(b) At a minimum, however, each Active Staff Appointee is required to attend 25% of applicable Service, division and committee meetings in each year. It is not necessary to prepare excuses for missed meetings because excuses shall not be considered when compliance with this attendance requirement is reviewed. Failure to meet this attendance requirement will be grounds for disciplinary action.

ARTICLE 7

QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES

7.A. Collegial Intervention:

(1) This policy encourages collegial and educational efforts by Medical Staff, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(2) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

(3) All collegial intervention efforts by Medical Staff are part of the Hospital's performance improvement and professional and peer review activities.

(4) The relevant member of the Medical Staff shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

(5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate member of the Medical Staff.

(6) The Chief of Staff, in conjunction with the Chief Executive Officer or designee, shall determine whether to direct that a matter be handled in accordance with another Policy adopted the by the Medical Staff or its Executive Committee or the Board, or to direct it to the Medical Staff Executive Committee for further determination.

7.B. Investigations:

(1) Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:

(i) the clinical competence or clinical practice of any Appointee to the Medical Staff, including the care, treatment or management of a patient or patients;

(ii) the known or suspected violation by any Appointee to the Medical Staff of applicable ethical standards or this Governance Policy,

Policies, Rules and Regulations of the Hospital or the Medical Staff; and/or

(iii) conduct by any Appointee to the Medical Staff that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the Appointee to work harmoniously with others, the matter may be referred to the Chief of Staff, the Service chief, the chair of a standing committee, the Chief Executive Officer, or the chair of the Board.

(b) The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the Medical Staff Executive Committee.

(c) No action taken pursuant to this Section shall constitute an investigation.

(2) Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Medical Staff Executive Committee, the Medical Staff Executive Committee shall review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to another Policy adopted by the Medical Staff, its Executive Committee or the Board. In making this determination, the Medical Staff Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Medical Staff Executive Committee to do so. The formal determination may be made by an affirmative vote of the Medical Staff Executive Committee, whether at a regularly called meeting, a specially called meeting or telephonically.

(b) The Medical Staff Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Medical Staff Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

(c) The Board may also determine to commence an investigation and may delegate the investigation to the Medical Staff Executive Committee, a subcommittee of the Board, or an ad hoc committee.

(d) The Chief of Staff shall keep the Chief Executive Officer, or designee, fully informed of all action taken in connection with an investigation.

(3) Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the Medical Staff Executive Committee shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an individual or ad hoc committee to conduct the investigation. Any ad hoc committee shall not include partners, or relatives of the individual being investigated, but may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician or dentist).

(b) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that

(i) the clinical expertise needed to conduct the review is not available on the Medical Staff; or

(ii) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

(iii) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

(c) The investigating committee may require a physical and mental examination of the individual by health care professional(s) acceptable to it. The results of such examination shall be made available for consideration by the investigating committee;

(d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

(e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside committee is not employed. When an outside committee is employed, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside committee's report, and within a total of 90-120 days of the commencement of the investigation. The foregoing time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within such time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

(f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions and recommendations.

(g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the efficient operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committees may consider:

(i) relevant literature and clinical practice guidelines, as appropriate;

(ii) all of the opinions and views that were expressed throughout the review, including report(s) from any outside consultants; and

(iii) any information or explanations provided by the individual under review.

(4) Recommendation:

(a) The Medical Staff Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Medical Staff Executive Committee may:

(i) determine that no action is justified;

(ii) issue a letter of guidance, warning, or reprimand;

(iii) impose conditions for continued appointment;

(iv) impose a requirement for monitoring or consultation;

(v) recommend additional training or education;

(vi) recommend reduction of Clinical Privileges;

(vii) recommend suspension of Clinical Privileges for a term;

(viii) recommend revocation of appointment and/or Clinical Privileges; or

(ix) make any other recommendation that it deems necessary or appropriate.

(b) A recommendation by the Medical Staff Executive Committee that would entitle the individual to request a hearing shall be forwarded to the Chief Executive Officer, who shall promptly inform the individual by special notice. The Chief Executive Officer shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the Medical Staff Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.

(d) In the event the Board considers a modification to the recommendation of the Medical Staff Executive Committee that would entitle the individual to request a hearing, the Chief Executive Officer shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

7.C. Precautionary Suspension Or Restriction Of Clinical Privileges:

(1) Grounds for Precautionary Suspension or Restriction:

(a) The Chief of Staff, a Service chief, the Chief Executive Officer, the Chief Medical Officer or the Board chair shall each have the authority to suspend or restrict all or any portion of an individual's Clinical Privileges whenever failure to take such action may result in imminent danger to the health of any individual (whether or not then ascertained).

(b) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review

action in and of itself. It shall not imply any final finding of responsibility for the situation or situations that caused the suspension or restriction.

(c) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer, the Chief of Staff, and the chair of the Credentials Committee, and shall remain in effect unless it is modified by the Chief Executive Officer, Chief Medical Officer or Medical Staff Executive Committee.

(2) Voluntary Action of Appointee:

Prior to the imposition of precautionary suspension or restriction, an Appointee may request that he or she voluntarily suspend or restrict all or a portion of his or her Clinical Privileges, in which case the applicable Clinical Privileges shall be suspended or restricted until removed or modified by the Medical Staff Executive Committee or until a final action is taken with respect to the subject matter of the voluntary suspension restrictions. Any voluntary restriction or suspension shall not be treated as a suspension or limitation imposed in any portion of this Governance Policy.

(3) Medical Staff Executive Committee Procedure:

(a) The Medical Staff Executive Committee shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Staff Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the efficient operation of the Hospital, depending on the circumstances.

(b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Staff Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Staff Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

(c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

(4) Care of Patients:

(a) Immediately upon the imposition of a precautionary suspension or restriction, the Chief of Staff or Chief Medical Officer assign to another individual with appropriate Clinical Privileges responsibility for care of the suspended individual's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.

(b) All Appointees have a duty to cooperate with the Chief of Staff, the Service chief, the Medical Staff Executive Committee, and the Chief Executive Officer in enforcing precautionary suspensions or restrictions.

7.D. Automatic Relinquishment:

(1) Failure to Complete Medical Records:

History and Physicals, Discharge Summaries, and electronic signatures on dictated reports not completed within thirty (30) days following patient discharge are delinquent. Operative Reports are delinquent if not completed within fourteen (14) days following patient surgery. Physicians will be placed on suspension for delinquent medical records. Physicians on suspension will be precluded from scheduling new surgical procedures or from admitting new patients or seeing new patients in consultation; however care of previously admitted patients or scheduled surgical procedures will be allowed. The suspension shall remain in effect until lifted by the Chief of Staff. In the event that a Physician shall be suspended more than once during any consecutive twelve (12) month period, the lifting of the suspension will require action by the Medical Staff Executive Committee. Physicians who have not completed History and Physicals and Discharge Summaries for any patients within forty-five (45) days of discharge or Operative Reports within thirty (30) days of surgery shall be deemed to have resigned from the Medical Staff.

(2) Action by Government Agency or Insurer:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below must be promptly reported to the Office of Medical Staff Services.

(b) An individual's appointment and Clinical Privileges shall be automatically relinquished if any of the following occur:

(i) Licensure: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's license.

(ii) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's DEA controlled substance authorization.

(iii) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.

(iv) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(v) Criminal Activity: Indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.

(c) Automatic relinquishment shall take effect immediately and continue until the matter is resolved, if applicable, and a request for reinstatement of appointment and privileges has been acted upon by the Credentials Committee, the Medical Staff Executive Committee, and the Board. Committee and Board approval may be waived by the Chief of Staff, or designee, when professional liability insurance coverage is reinstated and verified.

(3) Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment or Clinical Privileges, in response to a written request from the Credentials Committee, the Medical Staff Executive Committee, the Chief Executive Officer, or any other committee authorized to request such information, shall result in automatic relinquishment of all Clinical Privileges until the information is provided.

(4) Failure to Attend Special Conference:

(a) Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the Service chief or the Chief of Staff may require the individual to attend a special conference with selected members of the Medical Staff and/or with a standing or ad hoc committee of the Medical Staff.

(b) The notice to the individual regarding this conference shall be given by special notice at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

(c) Failure of the individual to attend the conference shall be reported to the Medical Staff Executive Committee. Unless excused by the Medical Staff Executive Committee upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's Clinical Privileges as the Medical Staff Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

ARTICLE 8

HEARING AND APPEAL PROCEDURES

8.A. Initiation Of Hearing:

(1) Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the Medical Staff Executive Committee makes one of the following recommendations:

(i) denial of initial appointment to the Medical Staff;

(ii) denial of reappointment to the Medical Staff;

(iii) revocation of appointment to the Medical Staff;

(iv) denial of requested Clinical Privileges;

(v) revocation of Clinical Privileges;

(vi) suspension of Clinical Privileges; or

(vii) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance).

(b) No other recommendations shall entitle the individual to a hearing.

(c) The hearing shall be conducted in as informal a manner as possible.

(d) The individual may request a hearing before the Board takes final action, if the Board makes any of these recommendations without a prior Medical Staff Executive Committee recommendation. In this instance all references in this Article to the Medical Staff Executive Committee shall mean the Board.

(2) Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

(a) issuance of a letter of guidance, warning, or reprimand;

(b) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consultation for his or her patients but need not get prior approval for the treatment);

(c) termination of temporary Clinical Privileges;

(d) automatic relinquishment of appointment or Clinical Privileges;

(e) imposition of a requirement for additional training or continuing education;

(f) precautionary suspension;

(g) denial of a request for leave of absence, or for an extension of a leave;

(h) determination that an application is incomplete;

(i) determination that an application will not be processed due to a misstatement or omission; or

(j) determination of ineligibility based on a failure to meet threshold criteria, a lack of need or resources or because of an exclusive contract.

8.B. The Hearing:

(1) Notice of Recommendation:

The Chief Executive Officer shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

(2) Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the Chief Executive Officer and shall include the name, address and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

(3) Notice of Hearing and Statement of Reasons:

(a) The Chief Executive Officer shall schedule the hearing and provide, by special notice, the following:

(i) the time, place, and date of the hearing;

(ii) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

(iii) the names of the hearing panel members and presiding officer (or hearing officer) if known; and

(iv) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a reasonable opportunity (not exceeding 30 days) to review and rebut the additional information.

(b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

(4) Witness List:

(a) At least 15 days before the hearing, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list shall include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the chair of the Hearing Panel or Presiding Officer as applicable, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

(5) Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

(i) The Chief Executive Officer, after consulting with the Chief of Staff, shall appoint a Hearing Panel composed of not less than three members, one of whom shall be designated as chair. The Hearing Panel shall be composed of Appointees the Medical Staff who did not actively participate in the matter at any previous level, physicians or laypersons not connected with the Hospital or a combination thereof. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. Employment by, or a contract with, the Hospital or an affiliate shall not preclude any individual from serving on the Hearing Panel.

(ii) The Hearing Panel shall not include anyone who is in direct economic competition with, or related to, or involved in a referral relationship with, the individual requesting the hearing.

(b) Presiding Officer:

(i) In lieu of a Hearing Panel Chair, the Chief Executive Officer may appoint a Presiding Officer who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.

(ii) If no Presiding Officer has been appointed, the chair of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one vote.

(iii) The Presiding Officer shall:

(A) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(B) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(C) maintain decorum throughout the hearing;

(D) determine the order of procedure;

(E) rule on all matters of procedure and the admissibility of evidence; and

(F) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(iv) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

(v) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

(i) As an alternative to a Hearing Panel, the Chief Executive Officer, after consulting with the Chief of Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

(ii) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, or the Hearing Officer or Presiding Officer, shall be made in writing within 10 days of receipt of notice to the Chief Executive Officer, who shall resolve the objection.

8.C. Pre-Hearing And Hearing Procedure:

(1) Provision of Relevant Information:

(a) The individual requesting the hearing is entitled to the following, subject to the condition that all documents and information be maintained as confidential and not disclosed or used for any purpose outside of the hearing:

(i) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(ii) reports of experts relied upon by the Medical Staff Executive Committee;

(iii) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(iv) copies of any other documents relied upon by the Medical Staff Executive Committee.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

(b) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners.

(c) Prior to the hearing, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant Clinical Privileges shall be excluded.

(e) Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual shall contact Hospital employees appearing on the Medical Staff Executive Committee's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

(2) Pre-Hearing Conference:

The Presiding Officer may require a representative (who may be counsel) for the individual and for the Medical Staff Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness's testimony and cross-examination.

(3) Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

(4) Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

(5) Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

(i) to call and examine witnesses, to the extent they are available and willing to testify;

(ii) to introduce exhibits;

(iii) to cross-examine in an appropriate and civil manner any witness on any matter relevant to the issues;

(iv) subject to (3) above, to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and

(v) to submit a written statement at the close of the hearing.

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(6) Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contain information sufficient to allow the Board to decide whether the individual is qualified for appointment and Clinical Privileges.

(7) Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

(8) Persons to be Present:

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief Executive Officer, the Presiding Officer or the Chief of Staff.

(9) Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the Chief Executive Officer on a showing of good cause.

(10) Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

8.D. Hearing Conclusion, Deliberations, and Recommendations:

(1) Order of Presentation:

The Medical Staff Executive Committee or its representatives shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

(2) Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and Clinical Privileges, the Hearing Panel shall recommend in favor of the Medical Staff Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

(3) Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing

statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

(4) Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the Chief Executive Officer. The Chief Executive Officer shall send by special notice a copy of the report to the individual who requested the hearing. The Chief Executive Officer shall also provide a copy of the report to the Medical Staff Executive Committee

8.E. Appeal Procedure:

(1) Time for Appeal:

Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer by special notice, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

(2) Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure to comply with this Governance Policy and/or Rules and Regulations of the Hospital or Medical Staff during or prior to the hearing, so as to deny a fair hearing; or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

(3) Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

(4) Nature of Appellate Review:

(a) The Chair of the Board shall appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made, or the Board may consider the appeal as a whole body.

(b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel (or Board) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(c) The Review Panel (or Board) 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. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel (or Board).

(d) The Review Panel shall recommend final action to the Board.

(5) Final Decision of the Board:

Within 30 days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall send special notice thereof to the individual. 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, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and Clinical Privileges. A copy shall also be provided to the Medical Staff Executive Committee for its information.

(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. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

(7) Right to One Hearing and One Appeal Only:

No applicant or Appointee of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment or Clinical Privileges of a current Appointee to the Medical Staff, that individual may not apply for staff appointment or for those Clinical Privileges for a period of five years unless the Board provides otherwise.

ARTICLE 9

CONFIDENTIALITY AND PEER REVIEW PROTECTION

9.A. Confidentiality:

Actions taken and recommendations made pursuant to this Governance Policy shall be strictly confidential. Individuals participating in peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

(1) when the disclosures are to another authorized Appointee of the Medical Staff or authorized Hospital employee and are for the purpose of conducting legitimate peer review activities;

(2) when the disclosures are authorized, in writing, by the Chief Executive Officer or by legal counsel to the Hospital. Any breach of confidentiality may result in a professional review action and/or appropriate legal action; or

(3) In accordance with the law of the State of Nebraska.

9.B. Peer Review Protection:

(1) All peer review activities pursuant to this Governance Policy and related Medical Staff documents shall be performed by peer review committees in accordance with applicable state law. Peer review committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) hearing panels;

(c) the Board and its committees;

(d) any individual acting for or on behalf of any such entity, including but not limited to Service chiefs, division coordinators, committee chairs and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities; and

(e) all services and divisions.

All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable state law.

(2) All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. ' 11101 *et seq*.

ARTICLE 10

CONFLICTS OF INTEREST

(1) When performing a function outlined in this Governance Policy, the Credentials Policy or Organization and Functions Manual, if any Medical Staff Appointee has or reasonably could be perceived as having a conflict of interest in any matter involving another individual, the individual with a conflict shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may be asked, and may answer, any questions concerning the matter before leaving.

(2) The existence of a potential conflict of interest or bias on the part of any Appointee may be called to the attention of the Chief of Staff or applicable committee chair or Service chief by any other Appointee with knowledge of it.

(3) The fact that a Service chief or Appointee is in the same specialty as an Appointee whose performance is being reviewed does not automatically create a conflict. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No Appointee has a right to compel a determination that a conflict exists.

(4) The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

ARTICLE 11

AMENDMENTS

This Governance Policy may be amended by either of the following procedures:

(1) The Medical Staff acting by majority vote of the Active Staff Appointees may initiate a change in this Governance Policy or any Policies ("Proposal"). The Medical Staff shall, after adoption by the Medical Staff, forward the Proposal to the Medical Staff Executive Committee for review and recommendation ("Report"). The Report shall be made as promptly as possible by the Medical

Staff Executive Committee to the Medical Staff. The Medical Staff may act on the Proposal after receiving the Report at its next regular meeting or a special meeting called for the purpose, inter alia, of considering the Proposal.

(2) The Medical Staff Executive Committee may initiate a change in this Governance Policy or any Policy ("Change"), provided that prior to adopting such Change notice shall be given to the Medical Staff of such Change. Any Change adopted by the Medical Staff Executive Committee shall be promptly communicated to the Medical Staff.

(3) Any adopted Change or Proposal shall be effective only after approval by the Board.

(4) In the event that a disagreement of any subject shall exist between the Medical Staff and the Medical Staff Executive Committee, the Medical Staff or the Medical Staff Executive Committee may request that a conference be held between representatives of the two (as selected by each). The Chief of Staff shall schedule the conference so that it is held within 30 days of the receipt of the request. The aim of the conference shall be to explain and attempt to reach consensus on unagreed issues.

(5) The foregoing notwithstanding as to any Proposals or Changes which are not adopted by the Board or other matters, either the Medical Staff or the Medical Staff Executive Committee may request a conference with the Board. In the case of such a need, the Chief of Staff shall contact the Chief Executive Officer who shall schedule a conference with the Board to be held within 2 weeks of the date of such request.

ARTICLE 12

RULES AND REGULATIONS OF THE MEDICAL STAFF

(1) Medical Staff Rules and Regulations, as may be necessary to implement more specifically the general principles of conduct found in this Governance Policy, shall be adopted in accordance with this Article. Rules and Regulations shall set standards of practice that are to be required of each individual exercising Clinical Privileges in the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as this Governance Policy.

(2) Rules and Regulations may be adopted, amended, repealed, or added by the Medical Staff Executive Committee, provided that the notice provisions provided in this Governance Policy are followed.

(3) Rules and Regulations may also be adopted, amended, repealed, or added by the Medical Staff at a regular meeting or special meeting called for that purpose provided that the procedure used in amending this Governance Policy is followed.

(4) Adoption of and changes to the Rules and Regulations shall become effective only when approved by the Board.

(5) The present Rules and Regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with this Governance Policy, until such time as they are amended in accordance with the terms of this Governance Policy. To the extent they are inconsistent; they are of no force and effect.

ARTICLE 13

INDEMNIFICATION

All Medical Staff officers, Service chiefs, committee chairs, committee members, and authorized representatives shall be indemnified when acting in those capacities, to the fullest extent permitted by law, in accordance with the Hospital's Bylaws.

ARTICLE 14

ADOPTION

This Governance Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Governance, Bylaws, Rules and Regulations, Policies, manuals or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:

Date: November 8, 2010

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Chief of Staff

Approved by the Board of Directors:

Date: November 15, 2010

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Chairperson, Board of Directors