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CHAPTER 1 DEFINITIONS

- 1.1 “Allied Health Professional” or “AHP” means an individual, licensed in the State of Wyoming as a podiatrist, psychologist, physician assistant, advanced practice register nurse, or dentist who is not an oral surgeon, who is not a Member of the Medical Staff as defined herein and is qualified by academic and clinical training to function in the Hospital and is granted some Clinical Privileges.
- 1.2 “Authorized Representative” or “Hospital’s Authorized Representative” means the individual designated by the Hospital and approved by the Executive Committee to provide information to the National Practitioner Data Bank according to the terms of these Bylaws.
- 1.3 “Board of Directors” or “Board” means the governing body of the Hospital.
- 1.4 “Chief Executive Officer” or “CEO” means the person appointed by the Board of Directors to serve as the head administrator of the Hospital.
- 1.5 “Clinical Privileges” or “Privileges” means the permission granted by the Board to provide patient care in the Hospital.
- 1.6 “Executive Committee” means the Executive Committee of the Medical Staff, which shall constitute the governing body of the Medical Staff as described in these Bylaws.
- 1.7 “Hospital” means Wyoming Medical Center or W.M.C.
- 1.8 “Focused Professional Practice Evaluation” or “FPPE” means a time-limited evaluation process during which there is an evaluation of a Practitioner. An FPPE may be used to determine the validity, if any, of a concern or complaint raised with respect to any Practitioner with Clinical Privileges. An FPPE may also occur as part of routine reviews, such as FPPEs of Practitioners after they receive Privileges for the first time and FPPEs routinely performed by the Peer Review Committee. FPPEs may be, but are not always, the precursor to a professional review action. Routine FPPEs are not “investigations” for purposes of reporting to the Data Bank.
- 1.9 “Practitioner” means a Physician, as defined in these Bylaws, Allied Health Professional, or other health care professional independently licensed to provide Clinical Privileges.
- 1.10 “Medical Staff” means those Physicians as defined herein who have been admitted as members of the Medical Staff in their respective capacities pursuant to the terms of these Bylaws.
- 1.11 “Medical Staff Year” means the period from July 1 to June 30.
- 1.12 “Ongoing Professional Practice Evaluation” or “OPPE” means a process during which the Medical Staff continuously evaluate a Practitioner’s professional performance, including but not limited to the Practitioner’s performance within the organization, resource utilization, observed clinical performance of skills, the documented results of

quality assessment and performance improvement activities, demonstrated competence since the previous appointment, pertinent information obtained from other sources, including other institutions where the Practitioner exercises Clinical Privileges, and evidence of sufficient use of Privileges since last evaluation.

- 1.13 “Oral Surgeons” shall be interpreted to refer to licensed dentists who have successfully completed a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.
- 1.14 “Physician”, for purposes of these Bylaws, means any individual with an M.D. or D.O. degree who is fully licensed by the Wyoming State Board of Medicine to practice medicine or osteopathy in the State of Wyoming and any individual who is an Oral Surgeons, as defined in 1.13.
- 1.15 “Special Attendance” means a request to a Medical Staff member from the Executive Committee, Credentials Committee or other Medical Staff committee to attend a meeting on a matter relating to the member’s Medical Staff membership or Clinical Privileges.
- 1.16 “Special Notice” means written notification sent by certified mail with return receipt requested.

CHAPTER 2 ESTABLISHMENT AND PURPOSE

The relationship between the Medical Staff and the Hospital is the following:

- (a) the relationship between the Hospital and the Medical Staff is not an employment relationship, but a privilege in the nature of a license to use the Hospital for the treatment of patients;
- (b) the Medical Staff is an advisor to the governing body when providing clinical expertise wherever that is important or relevant;
- (c) the Medical Staff will have input into all areas in which it should be involved;
- (d) the Medical Staff Bylaws serve as a framework for self-governance of Medical Staff activities but do not suggest that the Medical Staff is a separate entity but rather is part of the Hospital facility.

CHAPTER 3 MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

No Physician, including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless he or she is a member of the Medical Staff or has been granted Clinical Privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such Clinical Privileges and prerogatives as have been granted in accordance with these Bylaws. Membership is not a

right of any person. Every qualified person who seeks or enjoys Medical Staff membership must continuously meet and demonstrate to the satisfaction of the Medical Staff and the Board the qualifications, standards and requirements set forth in these Bylaws.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

Only Physicians who:

- (a) document their (1) current licensure, (2) board certification as set forth in Section 3.2-2 below, (3) adequate experience, education, and training, (4) current professional competence, (5) good judgment, and (6) adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff and the Board that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care; and
- (b) are determined (1) to adhere to the ethics of their profession, (2) to work with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information for records received in the patient relationship. (4) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff, and to be proficient in the following general competencies (a) Patient Care, (b) Medical/Clinical Knowledge, (c) Practice-Based Learning and Improvement, (d) Interpersonal and Communication Skills, (e) Professionalism, (f) Systems-Based Practice.

3.2-2 BOARD CERTIFICATION

- (a) All applicants for initial appointment must be board certified in the practice specialty for which Clinical Privileges are requested (or in a similar practice specialty as determined by the Credentials Committee), or must be board eligible in accordance with the timeframe allowed by the relevant board. At reappointment, members must be board certified or eligible in accordance with the timeframe allowed by the relevant board to be eligible for reappointment, except that this does not apply to Practitioners who, as of March 31, 2011, were on the Medical Staff and were not board certified, or who were board certified but were not then required to complete maintenance of certification. For purposes of the requirement, the relevant board must be a board which is accredited by the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialties or the accrediting boards of the American Association for Oral and Maxillofacial Surgery and American Board of Podiatric Surgery.
- (b) Exceptions to the requirements for initial certification and maintenance of certification may be granted for good cause, including, but not limited to the following:
 - a. Clerical error or inadvertently missing a required filing deadline;

- b. Illness or other situations not within the control of the individual, which prevents compliance with initial certification or maintenance of certification requirements or deadlines;
- c. Pending retirement; or
- d. A moral objection or concern.

The exceptions may take the form of a waiver of the requirements, extending the deadline to meet the requirements, an alternative to certification, such as a CME program, or some form of outside review and audit of the Practitioner's competence.

- (c) The following process shall be followed in addressing requests for exception to the board certification and maintenance of certification requirements:
 - a. The affected Practitioner shall submit a request for the exception, and the desired alternative, in writing to the Credentials Committee, together with any supporting documentation.
 - b. The Credentials Committee shall meet with the affected Practitioner for a full discussion of the issues, and shall then present a recommendation to the Medical Staff Executive Committee. The affected Practitioner is entitled to make a presentation to the Medical Staff Executive Committee.
 - c. The Medical Staff Executive Committee shall then make a recommendation to the Board of Directors Quality Committee, which shall then make a recommendation to the Board of Directors.

3.3 BASIC RESPONSIBILITIES OF MEMBERSHIP

The ongoing responsibilities of each member of the Medical Staff include:

- (a) providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital;
- (b) abiding by the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Medical Staff Policies;
- (c) discharging in a responsible manner such reasonable responsibilities and assignments imposed upon the member, by the Medical Staff, by virtue of Medical Staff membership, including committee assignments;
- (d) preparing and completing in a timely fashion medical records for all the patients to whom the member provides care in the Hospital by using the Hospital's approved electronic medical record system, provided that, exceptions may be granted by the Medical Executive Committee for good cause shown;

- (e) abiding by the lawful ethical principles of his/her profession and avoiding acts constituting unprofessional conduct under licensing laws and regulations of the State of Wyoming or fraud or other actionable conduct potentially subject to penalty or criminal sanction under federal and state laws and regulations;
- (f) aiding in any Medical Staff approved educational programs for medical students, interns, resident Physicians, staff Physicians and dentists, nurses and other personnel;
- (g) working with Medical Staff members, nurses, Hospital administration and others so as not to adversely affect patient care;
- (h) making appropriate arrangements for coverage for his or her patients as determined by the Medical Staff;
- (i) not engaging in any acts of discrimination prohibited by state or federal law;
- (j) complying with the *Principles of Partnership and Corporate Compliance Plan*;
- (k) participating in continuing education programs as determined by the Medical Staff;
- (l) participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff;
- (m) discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Executive Committee;
- (n) providing information to and/or testifying on behalf of the Medical Staff or Medical Staff member regarding any matter under evaluation, such as OPPE or FPPE, or the subject of a hearing;
- (o) paying all Medical Staff dues and assessments as may be set forth in these Bylaws or in the Rules and Regulations of the Medical Staff;
- (p) informing the Executive Committee, and the Credentials Committee of the following immediately after occurrence:
 - (1) any action taken by a hospital or health care institution to limit, restrict, deny, revoke, or suspend staff membership or Clinical Privileges;
 - (2) limitations, restrictions, suspension, lapse, or revocation of the member's professional license issued by the State of Wyoming, or any other state;
 - (3) limitation, restriction, suspension, lapse, or revocation of the member's narcotics license;

- (4) limitation, restriction, suspension, lapse, or revocation of malpractice liability insurance; or
- (5) change in physical or mental health affecting the ability to practice.
- (q) participating in the Medical Staff peer review process.

3.4 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the Medical Staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical Staff membership or Clinical Privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in contracts with a third party which contracts with the Hospital.

3.5 NONDISCRIMINATION

No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of sex, race, age, creed, color, national origin, or physical or mental impairment that does not pose a threat to the quality of patient care.

CHAPTER 4 CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The categories of the Medical Staff shall include active and consulting. At each time of reappointment, the member's staff category shall be determined.

4.1-1 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws and by the Medical Staff Rules and Regulations.

4.1-2 MODIFICATION OF MEMBERSHIP

The Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of these Bylaws on its own, upon recommendation of the Credentials Committee, pursuant to a request by a member, or upon direction of the Board of Directors.

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS

The Active Staff shall consist of members who:

- (a) meet the general qualifications for membership set forth in Section 3.2;
- (b) have offices and residences which, in the opinion of the Executive Committee, are located close enough to the Hospital for the member to be present, if necessary, within thirty (30) minutes of being contacted, provided that, the Medical Executive Committee may waive this requirement for good cause; and
- (c) regularly admit or care for patients in Hospital, provided that this requirement regarding regular admission or care does not apply to Physicians holding only Ambulatory Care Privileges.

4.2-2 PREROGATIVES

Except as otherwise provided, the prerogatives of an Active Staff member shall be to:

- (a) admit patients and exercise such Clinical Privileges as are granted pursuant to Chapter 6;
- (b) attend and vote on matters presented at general and special meetings of the Medical Staff and of the department and committees of which he or she is a member; and

- (c) hold staff, division, or department office and serve as a voting member of committees to which he or she is duly appointed or elected by the Medical Staff or duly Authorized Representative thereof.

4.2-3 TRANSFER OF ACTIVE STAFF MEMBER

If a Member of the Active Staff fails to regularly admit or care for patients in the Hospital, that Member shall be automatically transferred to the appropriate category, if any, for which the Member is qualified.

4.3 THE CONSULTING MEDICAL STAFF

4.3-1 QUALIFICATIONS

The Consulting Medical Staff shall consist of Members who:

- (a) meet the general qualifications set forth in Section 3.2;
- (b) have offices and residences which, in the opinion of the Executive Committee, are located close enough to the Hospital for the member to be present, if necessary, within thirty (30) minutes of being contacted, provided that, the Executive Committee may waive this requirement for good cause; and
- (c) regularly provide consultations for patients in the Hospital, although exceptions to this requirement may be made by the Executive Committee for good cause.

4.3-2 PREROGATIVES

Except as otherwise provided, the Consulting Medical Staff member shall be entitled to:

- (a) exercise such Clinical Privileges as are granted pursuant to Chapter 6; and
- (b) attend, in a non-voting capacity, meetings of the Medical Staff and the department of which he or she is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

CHAPTER 5 APPOINTMENT

5.1 RIGHTS AND DUTIES OF APPOINTEES

Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been granted by the Board and shall require that each appointee assume such reasonable duties and responsibilities as the Board or the Executive Committee shall require.

5.2 INFORMATION

Requests for applications and applications for appointment to the Medical Staff shall be in writing. Upon receipt of a request for an application to the Medical Staff, a pre-application questionnaire regarding threshold eligibility criteria and an application will be sent to the individual requesting the application. No application will be processed until a completed pre-application questionnaire, confirming that the threshold eligibility criteria, is received by the Hospital. The denial of or refusal to accept an application to the Medical Staff that occurs solely due to failure to meet the threshold eligibility criteria, and that is not based on professional competence or conduct, is not reported to the National Practitioner Databank. The application shall require detailed information concerning the applicant's professional qualifications including:

- (a) the names of at least two (2) individuals, who have had recent extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's present professional competence and character;
- (b) information as to whether the applicant's Medical Staff appointment or Clinical Privileges have ever been denied, revoked, suspended, reduced or not renewed at any other hospital or health care facility, either voluntarily or involuntarily;
- (c) information as to whether the applicant's membership in local, state or national professional societies or his license to practice any profession in any state, or his narcotic license has ever been suspended, modified or terminated, voluntarily or involuntarily. The submitted application shall include a copy of all the applicant's current licenses to practice, as well as a copy of the applicant's narcotics license, medical or dental school diploma, and certificates from all post graduate training programs completed;
- (d) information on whether the applicant meets the Board Certification criteria set forth in Section 3.2-2;
- (e) information as to whether the applicant has currently in force professional liability insurance coverage in a minimum amount as prescribed by the Board, the name of the insurance company and the amount and classification of such coverage;
- (f) involvement in a professional liability action at least to include final judgments;

- (g) the National Practitioner Data Bank will be queried upon application, at subsequent reappointments, and other times as deemed necessary, and that information will become part of the evaluation process;
- (h) a consent to the release of information from his present and past malpractice insurance carriers;
- (i) a request for the specific Clinical Privileges desired by the applicant;
- (j) information on the applicant's physical or mental health;
- (k) information as to whether the applicant has ever been named as a defendant in a criminal action and details about any such instance;
- (l) information on the citizenship and visa status of the applicant;
- (m) the applicant may be required to undergo a physical or mental examination, at his expense, by a physician or physicians satisfactory to the Credentials Committee. The results will be made available for the committee's consideration;
- (n) the Credentials Committee shall have the right to require the applicant to meet with the committee to discuss any aspect of his application, his qualifications, and his Clinical Privileges;
- (o) information regarding the applicant's experience performing the requested Privileges, including a procedure log if the Clinical Privileges require a minimum number of procedures performed;
- (p) the applicant shall submit such other information as may be required.

5.3 UNDERTAKINGS

Every application for Medical Staff appointment shall be signed by the applicant and shall contain the following statements which are express conditions applicable to any Medical Staff applicant, any appointee to the Medical Staff and to all others having or seeking Clinical Privileges in the Hospital. By applying for appointment, reappointment or Clinical Privileges, the applicant expressly accepts these conditions during the processing and consideration of his application, whether or not the applicant is granted appointment or Clinical Privileges. This acceptance also applies during the time of any appointment or reappointment.

- (a) the applicant's specific acknowledgment of his obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the Hospital for whom he has responsibility;
- (b) the applicant's agreement to abide by all bylaws and policies of the Hospital, as shall be in force from time to time during the time the applicant is appointed to the Medical Staff, including, but not limited to, the Bylaws and Rules and

Regulations of the Medical Staff, the Principles of Partnership, and the Corporate Compliance Plan;

- (c) the applicant's agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him by the Board and the Medical Staff;
- (d) a statement that the applicant has received and read a copy of such Bylaws of the Hospital and Bylaws, Rules and Regulations of the Medical Staff and the Rules of Practice and Procedures governing Medical Staff hearings as are in force at the time of his application and that he has agreed to be bound by the terms thereof in all matters relating to consideration of his application without regard to whether or not he is granted appointment to the Medical Staff or Clinical Privileges;
- (e) a statement that the applicant will:
 - (1) refrain from fee splitting or other illegal inducements relating to patient referral;
 - (2) refrain from delegating responsibility for diagnosis or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;
 - (3) refrain from deceiving patients as to the identity of any individual providing treatment or services;
 - (4) seek consultation whenever necessary; and
 - (5) abide by generally recognized ethical principles applicable to his profession.

5.4 BURDEN OF PROVIDING INFORMATION

The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications. He shall have the burden of providing evidence that all the statements made and information given on the application are factual and true. Until the applicant has provided all information requested, the application shall be deemed incomplete and will not be processed. If it is determined that the application is incomplete, the application will not be processed further unless sufficient information is provided to complete the application. If the applicant fails to provide requested information within twenty days of a request, the application will be considered withdrawn.

5.5 RELEASE

5.5-1 IMMUNITY

To the fullest extent permitted by law, the applicant or appointee releases from any and all liability, and extends absolute immunity to the Hospital, its authorized representatives and any third parties as defined in subsection 5.5-3 below, with respect to any acts, communications or documents, recommendations or disclosures involving the applicant or appointee, concerning the following:

- (a) applications for appointment or Clinical Privileges, including Temporary Privileges;
- (b) evaluations concerning reappointment or changes in Clinical Privileges;
- (c) Focused Professional Practice Evaluation;
- (d) Ongoing Professional Practice Evaluation;
- (e) proceedings for suspension or reduction of Clinical Privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction;
- (f) summary suspension;
- (g) hearings and appellate reviews;
- (h) medical care evaluations;
- (i) utilization reviews;
- (j) other activities relating to the quality of patient care or professional conduct;
- (k) matters or inquiries concerning the applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or
- (l) any other matter that might directly or indirectly have an effect on the individual's competence, on patient care or on the orderly operation of this or any other hospital or health care facility. The foregoing acts, communications and documents, shall be privileged to the fullest extent permitted by law. Such privileges shall extend to the Hospital and its authorized representatives, and to any third parties.

5.5-2 AUTHORIZATION TO OBTAIN INFORMATION

The applicant or appointee specifically authorizes the Hospital and its authorized representatives to consult with any third party who may have information bearing on the applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other

matter reasonably having a bearing on his satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be material to such questions. The applicant or appointee also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request.

5.5-3 DEFINITIONS

- (a) As used in this section, the term “Hospital and its authorized representatives” means the members of the Hospital Board and their appointed representatives, the Chief Executive Officer and his designees, consultants to the Hospital, the Hospital’s attorney and his partners, associates or designees, the Chief of the Medical Staff or his designees, and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the applicant’s or appointee’s credentials, or acting upon his application or conduct in the Hospital.
- (b) As used in this section, the term “third parties” means all individuals, including appointees to the Hospital’s Medical Staff, and appointees to the medical staffs of other hospitals or other healthcare providers, nurses or other organizations, associations, partnerships and corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives.

5.6 APPLICATION PROCESS

- (a) Applications for Medical Staff appointment and Clinical Privileges, unless otherwise stated in these Bylaws, shall be processed in accordance with the Medical Staff procedure applicable to reappointment.
- (b) In the event the recommendation of the Executive Committee is adverse to the applicant in respect to either appointment to the Medical Staff or for Clinical Privileges requested, the applicant shall be entitled to the Medical Staff hearing process, as outlined in these Bylaws.

CHAPTER 6 CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, a member of the Medical Staff or Allied Health Professional providing clinical services at Wyoming Medical Center shall be entitled to exercise only those Clinical Privileges specifically granted. Privileges and services shall be within the scope of any license, certificate or other legal credential authorizing medical practice in the State of Wyoming, and shall be subject to the rules and regulations for delineations of Privileges specific for the clinical department, and to the authority of the Department Chair, and to the Executive Committee. Clinical Privileges may be granted, continued, modified or terminated by the Board of Directors only upon recommendation of the Executive Committee, and only following the procedures outlined in these Bylaws and the Procedures for Appointment and Reappointment.

6.2 DELINEATION OF PRIVILEGES IN GENERAL

6.2-1 REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the applicant. A request by a member for a modification of Clinical Privileges may be made at any time, but such requests must be supported by documentation of required training and experience supportive of the request.

6.2-2 RESOURCE AVAILABILITY

Before the granting of Clinical Privileges, the Board, through the Medical Staff Development Committee must have determined that the resources necessary to support the requested Clinical Privileges are currently available or are available within a specified time frame and that the Clinical Privileges are within the Hospital's approved scope of services.

6.2-3 BASIS FOR PRIVILEGES DETERMINATION

Requests for Clinical Privileges shall be evaluated on the basis of current licensure and board certification, verified with the primary source, the applicant's specific relevant training, verified with the primary source, the applicant's specific relevant experience, evidence of physical ability to perform the requested Privileges, data from professional practice review by an organization that currently privileges the applicant (if available), peer and/or faculty recommendation, and other relevant information.

6.2-4 REAPPOINTMENT

Requests for reappointment of Clinical Privileges shall be evaluated on the basis of all of the above plus Ongoing Professional Practice Evaluation including but not limited to the Practitioner's performance within the organization, resource utilization, observed clinical

performance of skills, the documented results of quality assessment and performance improvement activities, demonstrated competence since the previous appointment, pertinent information obtained from other sources, including other institutions where the Practitioner exercises Clinical Privileges, and evidence of sufficient use of Privileges since last evaluation. When an applicant for reappointment has had inadequate clinical activity in a procedural skill, he may be required to have that procedural skill subjected to an FPPE or proctored or observed by an Active member of the Medical Staff currently Privileged in that area. Such a requirement shall not constitute a reduction in Clinical Privileges.

6.2-5 FOCUSED PROFESSIONAL PRACTICE EVALUATION

As appropriate, all Practitioners who receive Clinical Privileges for the first time shall have their Clinical Privileges subject to a Focused Professional Practice Evaluation (“FPPE”). Further, all Practitioners who already hold Clinical Privileges, requesting new Clinical Privileges shall be subject to an FPPE. This FPPE shall include peer recommendations, which include written information regarding the Practitioner’s current: medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. This requirement shall not apply to Physicians with Ambulatory Care Privileges.

The appropriate Department Chair or the Credentials Committee shall determine the type of FPPE and the number, if any, of written observation reports required for an FPPE of Practitioners who receive Clinical Privileges for the first time. If written observation reports are required and the minimum number of reports are not obtained and provided within 6 months of commencing to exercise Clinical Privileges in the Hospital, the Department Chair may issue the Practitioner a notice of delinquency. If the Practitioner fails to obtain the required number of written observation reports within a reasonable time after the notice of delinquency, as determined by the Department Chair, the Department Chair may recommend that additional action be taken.

6.3 GRANTING OF PRIVILEGES WITHOUT APPOINTMENT

6.3-1 GENERAL

A Practitioner who has not been appointed to the Medical Staff shall not be permitted to render care to patients or provide medical services in the Hospital, except as authorized in this Section 6.3 or Chapter 8 if an Allied Health Professional. Reports of the granting of all Privileges without appointment shall be submitted to the Credentials Committee and Medical Executive Committee for information. Denial, termination, suspension or non-renewal of Clinical Privileges granted under this Section 6.3 shall not entitle the individual concerned to any of the procedural rights with respect to hearings.

6.3-2 TEMPORARY PRIVILEGES

Temporary Privileges may be granted to a Practitioner: (i) to fulfill important patient care, treatment and service needs; or (ii) when a new applicant with a complete

application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Governing Body.

- (a) When Temporary Privileges are granted for an important patient care need, they are not granted for greater than 120 days and the Medical Staff verifies current licensure and current competence before granting the Temporary Privileges and upon any renewal. Any such decision to grant Temporary Privileges will be revisited prior to the conclusion of this 120-day period to determine whether the medical necessity remains.
- (b) Temporary Privileges for *locum tenens* may be granted for an important patient care need upon verification of: current licensure, relevant training or experience, current competence, ability to perform the Privileges requested, a query of the Data Bank, a complete application, an investigation showing no current or previous successful challenge to licensure or registration, and an investigation showing no involuntary termination of medical staff membership or limitation of Clinical Privileges at another organization. Such Privileges will not be granted for greater than 120 days. Any such decision to grant Temporary Privileges for *locum tenens* may be revisited prior to the conclusion of this 120-day period to determine whether the medical necessity remains.
- (c) Temporary Privileges for new applicants that are granted while awaiting review and approval may be granted upon verification of: current licensure, board certification requirements, relevant training or experience, current competence, ability to perform the Privileges requested, a query of the Data Bank, a complete application, an investigation showing no current or previous successful challenge to licensure or registration, and an investigation showing no involuntary termination of medical staff membership or limitation of Clinical Privileges at another organization. Such Privileges for new applicants will not be granted for greater than 120 days.
- (d) All Temporary Privileges are granted by the Chief Executive Officer or authorized designee. Authorized designee for purposes of Temporary Privileges includes the Chief of Staff.
- (e) The Chief Executive Officer or authorized designee, may at any time, with or without a recommendation from the Department Chair responsible for the individual's supervision, and the Credentials Committee Chair, terminate an individual's Temporary Privileges. If the termination occurs while an individual has inpatients, the appropriate Department Chair, or, in his absence the Chief Executive Officer or designee, shall assign a Medical Staff appointee the responsibility of such terminated individual's patients until they are discharged from the Hospital, giving consideration whenever possible to the wishes of the patient in the selection of the substitute.
- (f) Temporary Privileges granted for a new applicant shall be automatically terminated if the Credentials Committee recommends unfavorably with respect to

an applicant's appointment to the Medical Staff, or at the Credentials Committee's discretion the Privileges may be modified to conform to the recommendation of the Credentials Committee.

- (g) All individuals given Temporary Privileges shall be subject to a Focus Professional Practice Evaluation as set forth in 6.2-5.

6.3-3 TELEMEDICINE PRIVILEGES

Pursuant to applicable regulatory and accreditation provisions, and in accordance with other applicable policies, Telemedicine Privileges may be granted by the Board to Practitioners who are not members of the Medical Staff, and who prescribe, render a diagnosis or otherwise provide clinical treatment to a patient in the Hospital by means of telemedicine, from either a hospital or telemedicine site outside the Hospital (the "Distant Site"). In order to be eligible for Telemedicine Privileges, Practitioners must hold a license issued by or recognized by the state where the patient receiving the services is located and meet the Board Certification criteria set forth in Section 3.2-2. "Telemedicine" means the provision of clinical services to patients by Practitioners and Practitioners from a distance via electronic communications. Telemedicine does not include a consultation provided by telephone, electronically by members of the Medical Staff, or facsimile machine.

In the credentialing process, the Medical Staff and Board may rely on credentialing information from the Distant Site if the Practitioner has clinical privileges at the Distant Site, the Hospital has entered into a written arrangement with the Distant Site that complies with and meets all applicable regulatory and accreditation requirements for telemedicine credentialing. If the Hospital does not have such a written arrangement with the Distant Site, the Applicant must complete the application and reappointment process as otherwise provided by these Bylaws and the Medical Staff and Board may not rely on the credentialing process of the Distant Site. The Medical Staff must have and review a current list of the Practitioner's clinical privileges at the Distant Site and evidence of an internal review of the Practitioner's performance of its clinical privileges. The Hospital must also send the Distant Site performance information for use in the periodic appraisal of the Practitioner by the Distant Site. This information must include all adverse and sentinel events that result from the telemedicine services provided by the Practitioner and all complaints the Hospital has received about the Practitioner, including complaints from patients, other Practitioners, and staff. Any information shared must be done in a manner to preserve any confidentiality or privilege established by applicable law. Nothing contained in this section shall prohibit the Medical Staff or the Board from requesting additional information from an individual applying for Telemedicine Privileges or from requiring that such individual be credentialed through the standard appointment procedures.

Practitioners holding Telemedicine Privileges are not members of the Medical Staff. Telemedicine Privileges may be terminated at any time by the Chief of Staff or Chief Executive Officer.

6.3-4 DISASTER PRIVILEGES

When the *Disaster Plan* has been implemented and the immediate needs of patients in the facility cannot be met, the Chief of Staff or Chief Executive Officer may use a modified credentialing process to grant Disaster Privileges to eligible volunteer Practitioners. Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

Disaster Privileges are granted on a case-by-case basis after verification of identify and licensure.

The Medical Staff will oversee the care provided by volunteer Practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

6.3-5 EMERGENCY PRIVILEGES

In the case of an emergency, any member of the Medical Staff with Clinical Privileges shall be permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm, to the degree permitted by the scope of the Practitioner's license and regardless of Medical Staff status or specific Privileges. The Practitioner shall make every reasonable effort to communicate promptly with the Chief Executive Officer or the Chief of Staff concerning the need for emergency care and assistance by members of the Medical Staff with appropriate Privileges, and once the emergency has passed or assistance has been made available, shall defer to the Chief Executive Officer or the Chief of Staff with respect to further care of the patient at the Hospital.

In the event of an emergency, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available.

6.4 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, upon recommendation of the Credentials Committee, or pursuant to a request under the Bylaws section dealing with reappointments and requests for modification of Medical Staff status or Clinical Privileges, the Executive Committee may recommend a change in the Clinical Privileges or department assignment(s) of a member of the Medical Staff. The Executive Committee may also recommend that the granting of additional Privileges to a current Medical Staff member be made subject to monitoring in accordance with procedures similar to those outlined in Section 6.7.

6.5 APPLICATION FOR INCREASED CLINICAL PRIVILEGES

Whenever, during the term of his appointment to the Medical Staff, an individual desires to increase his Clinical Privileges, he shall apply in writing to the Department Chair on a form approved by the Department and the Board. The application shall state in detail the

specific additional Clinical Privileges desired and the applicant's relevant recent training and experience which justify increased Privileges. Thereafter, it will be processed in accordance with the Increased Clinical Privileges Policy.

6.6 CLINICAL PRIVILEGES FOR NEW PROCEDURES

Requests for Clinical Privileges to perform either a significant procedure not currently being performed at the Hospital or a significant new technique to perform an existing procedure ("new procedure") will not be processed until (a) a determination has been made that the procedure will be offered by the Hospital and (b) criteria to be eligible to request those Clinical Privileges have been established.

The Credentials Committee and the Medical Executive Committee shall make a preliminary recommendation as to whether the new procedure should be offered to the community. Factors to be considered by the Credentials Committee and the Medical Executive Committee include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at other, similar hospitals and the experiences of those institutions, whether there is any empirical evidence of a potential for patient harm, and whether the Hospital has the capabilities, including support services, to perform the new procedure.

If it is recommended that the new procedure be offered, the Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff and those outside the Hospital, and develop recommendations regarding (a) the minimum education, training, and experience necessary to perform the new procedure, and (b) the extent of monitoring and supervision that should occur if the Privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

6.7 CLINICAL PRIVILEGES THAT CROSS SPECIALTY LINES

Requests for Clinical Privileges that traditionally at the Hospital have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the Clinical Privileges in question.

The Department Chair shall conduct research and consult with experts, including those on the Medical Staff (e.g., individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

The Credentials Committee, in conjunction with the Department Chair, may recommend that individuals from different specialties be permitted to request the Privileges at issue. If such a recommendation is made, the Committee may make recommendations to the Department Chair regarding:

- (a) the minimum education, training, and experience necessary to perform the Clinical Privileges in question;
- (b) the clinical indications for when the procedure is appropriate;
- (c) the extent of monitoring and supervision that should occur if Privileges were to be granted; and
- (d) the manner in which the procedure would be reviewed as part of the Hospital's ongoing performance improvement activities (including an assessment of outcomes data for all relevant specialties).

The Department Chair shall forward these recommendations to the Executive Committee, who shall review the matter and make additional recommendations concerning the impact, if any, on emergency call responsibilities. The Executive Committee shall forward its recommendations to the Board for final action.

6.8 AMBULATORY CARE PRIVILEGES

Qualified Physicians on the Medical Staff that specialize in internal medicine, family practice, and pediatrics may be granted Ambulatory Care Privileges in lieu of other Privileges when hospitalists provide all inpatient care to their patients who are admitted in the Hospital. Physicians with Ambulatory Care Privileges may, when appropriate, order outpatient testing and treatment, provided they are responsible for the care of the patient, meet applicable licensing requirements, and are acting within their scope of practice under state law. Ambulatory Care Privileges do not include the ability to admit patients, perform surgical or invasive procedures, or otherwise treat and consult on Hospital inpatients. Physicians holding Ambulatory Care Privileges may, when appropriate, perform histories and physical examinations on patients prior to admission to the Hospital. However, upon admission as an inpatient or registration as an outpatient, the attending Physician will be responsible for updating the patient's history and physical. When appropriate, Physicians with Ambulatory Care Privileges may also, for example, visit their patients in the Hospital, review their patients' medical records, receive information concerning the patients' medical condition and treatment, and make entries in the patients' medical record maintained at the Hospital. However, Physicians with Ambulatory Care Privileges may not enter orders in Hospital's records for inpatients. Physicians with Ambulatory Care Privilege may, however, provide the Hospital with orders for end of life care, such as POLST, for the Hospital to add to a patient's medical records.

CHAPTER 7 REAPPOINTMENT AND REQUESTING CLINICAL PRIVILEGES

7.1 APPLICATION

Each current appointee, who has been granted Clinical Privileges, and who wishes to be reappointed to the Medical Staff and/or continue to hold Clinical Privileges shall be responsible for completing the reappointment application form approved by the Medical Staff and the Board. The application shall be submitted to the Department Chair prior to the expiration of the Practitioner's then current appointment in accordance with the Procedure for Reappointment. The Department Chair shall process the application. Failure to submit an application in a timely manner will result in automatic expiration of the appointee's appointment and Clinical Privileges at the end of the then current reappointment period. Reappointments shall be for a period of not more than two (2) years.

7.2 FACTORS TO BE CONSIDERED

Each recommendation concerning reappointment of a person currently appointed to the Medical Staff or a change in Medical Staff category, where applicable, shall be based upon:

- (a) such appointee's professional ethics, competence, clinical judgment in the treatment of patients, maintained satisfaction of the applicable threshold eligibility criteria, and physical and mental capacity to treat patients;
- (b) for Active Staff, admission or regular care of at least 20 patients during the reappointment period, although exceptions to this requirement may be made by the Executive Committee for good cause;
- (c) for Consulting Staff, provision of consultation for patient contact during the reappointment period, although exceptions to this requirement may be made by the Executive Committee for good cause;
- (d) current experience performing the requested Privileges, including, when applicable, documented procedures logs;
- (e) attendance at Medical Staff meetings and participation in Medical Staff affairs;
- (f) compliance with the Hospital Bylaws and policies pertaining to patient care and the Medical Staff Bylaws, Rules and Regulations;
- (g) behavior and cooperation with Hospital personnel;
- (h) use of the Hospital's facilities for patients, cooperation and relations with other Practitioners, and attitude toward patients, the Hospital and the public, and its impact on the quality of care;
- (i) physical health;

- (j) mental health; and
- (k) Ongoing Professional Practice Evaluation.

7.3 DEPARTMENT PROCEDURE

The Department Chair shall make recommendations for reappointment, increase in Clinical Privileges, or decrease in Clinical Privileges based on review of relevant recent training, observation of patient care provided, review of the records of patients treated in the Hospital or other hospitals, other records of the Medical Staff which evaluate the appointee's participation in the delivery of medical care, and other relevant information in compliance with any credentialing policy so developed by the Board in regard to granting specific Privileges.

7.4 CREDENTIALS COMMITTEE PROCEDURE

- (a) The Credentials Committee, after receiving recommendations from the Department Chair of each department, shall review all pertinent information available including all information provided from other committees of the Medical Staff and from Hospital management for the purpose of determining its recommendations for Medical Staff reappointment, for change in Medical Staff category, and for the granting of Clinical Privileges for the ensuing two (2) years.
- (b) The Credentials Committee may require that a person currently seeking reappointment procure a physical or mental examination, at the applicant's own expense, by a physician or physicians satisfactory to the Committee either as part of the reapplication process or during the appointment year to aid it in determining whether Clinical Privileges should be granted or continued and make results available for the committee's consideration. Failure of the person seeking reappointment to procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary relinquishment of all Medical Staff and Clinical Privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.
- (c) The Credentials Committee shall transmit its report and recommendations to the Executive Committee for review. Thereafter the Executive Committee shall forward its recommendations to the Board in a timely manner for consideration. Where an adverse action is recommended, the reason for such recommendation shall be stated, documented, and included in the report. The Chair of the Credentials Committee or his designee shall be available to the Executive Committee and to the Board to answer any questions that may be raised with respect to the recommendation. In such cases where an adverse action is recommended, the report shall not be transmitted to the Board until the affected individual has exercised or has been deemed to have waived his right to a hearing as provided in these Bylaws.

7.5 MEETING WITH AFFECTED INDIVIDUAL

If during the processing of a particular individual's file, the Credentials Committee or its Chair determines, in consultation with the Chief Medical Officer, that, due to extraordinary circumstances, an in-person meeting with the individual may benefit the decision making process, the Chair of the Credentials Committee may request the individual meet with the Credentials Committee prior to any final recommendation by the Credentials Committee. If the individual fails to meet with the Credentials Committee within ninety (90) days of a request regarding an initial application or an application for reappointment, the application will be denied as incomplete. The Chair of the Credentials Committee may extend this deadline for good cause, at the Chair's discretion. At the meeting, the affected individual may be informed of the general nature of the evidence supporting the action contemplated and invited to discuss, explain or refute it. This interview shall not constitute a hearing and the rules of a hearing shall not apply. There shall be no recording or transcription of this meeting and nothing stated at the meeting conference shall be admissible during any hearing proceedings or in any other forum. However, the committee shall indicate as part of its report to the Executive Committee whether such a meeting occurred.

7.6 FORWARDING TO THE BOARD

Any adverse recommendation by the Executive Committee listed in Section 12.2-1 of these Bylaws shall entitle the affected individual to the procedural rights provided in these Bylaws. The Chief Executive Officer shall then promptly notify the individual of the recommendation by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived his right to a hearing as provided in these Bylaws.

CHAPTER 8 ALLIED HEALTH PROFESSIONALS

8.1 GENERAL

For purposes of these Bylaws, Allied Health Professionals who are not members of the Medical Staff but may qualify for Clinical Privileges if they:

- (a) are employed by Medical Staff members to assist them in the care of their patients in the Hospital;
- (b) are recommended by a single sponsoring member of the Medical Staff; or
- (c) provide patient care services are provided within the scope of their education, training, Wyoming license, and professional certification, as well as in accordance with the specific Clinical Privileges granted.

Allied Health Professionals and their provision of care in the Hospital are subject to these Bylaws and rules and regulations of the Medical Staff, as well as any Hospital policies and procedures, Hospital approved position descriptions, and any local, state, or national requirements applicable to a particular category of Allied Health Professionals. Allied Health Professionals are not considered Medical Staff members nor shall they have any of the prerogatives or responsibilities of Medical Staff membership.

8.2 QUALIFICATIONS

Individuals must meet the qualifications specific to each category's Hospital approved position description or category requirement to be considered for appointment as Allied Health Professionals. Only Allied Health Professionals whose category of patient care has been approved by the Board of Directors may apply for Clinical Privileges.

8.3 PROCEDURE

Individuals seeking Clinical Privileges as an Allied Health Professional, as well as Medical Staff members or contracted agencies requesting the use of an Allied Health Professionals shall first submit an application to the CEO or his designee according to the Allied Health Professional - Initial Appointment Policy. For Allied Health Professionals employed by Medical Staff members to assist them in the care of their patients in the Hospital, the application shall include from the sponsoring Medical Staff member a request for sponsorship, acceptance of responsibility for all acts of the Allied Health Professional and a delineation of all proposed duties and tasks of the Allied Health Professional. The completed application shall be reviewed by the Department Chair for his recommendation which will then be forwarded to the Credentials Committee. The Credentials Committee shall evaluate the application based on the Board resolutions or a Medical Staff Development Plan recommendation that the practice of the Allied Health Professional would enhance the goals and objectives of the Hospital and of the Medical Staff. The Credentials Committee may then recommend to the Medical Executive Committee approval of the Allied Health Professional's Clinical Privileges, as requested or with alterations. Upon receipt and review of the Medical Executive Committee's

recommendation, the Board of Directors may notify, in writing, the individual, Medical Staff member, or contracted agency of the Allied Health Professional's status and Clinical Privileges or job description. Appointments and Reappointments of Allied Health Professionals shall be for a period of not more than two (2) years. Requests for reappointment of Clinical Privileges shall be evaluated on the basis of all of the above plus Ongoing Professional Practice Evaluation including but not limited to the following, as pertinent to the Allied Health Professional's scope of practice, the Allied Health Professional's performance within the organization, resource utilization, observed clinical performance of skills, the documented results of quality assessment and performance improvement activities, demonstrated competence since the previous appointment, pertinent information obtained from other sources, including other institutions where the Allied Health Professional exercises Clinical Privileges, and evidence of sufficient use of Privileges since last evaluation.

8.3-1 PROFESSIONAL LIABILITY INSURANCE

Each Allied Health Professional must maintain in force and furnish proof of professional liability coverage either on its own or under the auspices of the sponsoring Medical Staff member in not less than the minimum amount required by the Board of Directors for all Active Medical Staff members.

8.3-2 TERMINATION OF CLINICAL PRIVILEGES

An Allied Health Professional's Clinical Privileges may be reduced or terminated by the Chief of Staff, Executive Committee, or the Administration. In such circumstances, there is no right to a hearing pursuant to these Bylaws. Certain conflicts/disputes concerning Allied Health Professionals will be handled in accordance with the Allied Health Professional Conflict Resolution Policy.

8.3-3 RENEWAL

Allied Health Professionals shall be reviewed on a biennial basis. The conditions for renewal are set forth in the Allied Health Professionals – Renewal Policy and Procedures. Any request for changes in the scope of activities previously approved for an Allied Health Professional must be submitted, in writing, to the Department Chair, and must be received by the Credentials Committee and the Executive Committee of the Medical Staff prior to consideration by the Board of Directors.

CHAPTER 9 ORGANIZATION OF THE MEDICAL STAFF

9.1 OFFICERS OF THE MEDICAL STAFF

9.1-1 CATEGORIES

Officers of the Medical Staff shall be the Chief of Staff, the Vice Chief of Staff, and Secretary/Treasurer. Officers must continuously be members of the Active Staff at the time of election and during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

9.1-2 ELECTION

Within thirty (30) days before the scheduled day at the end of the Medical Staff year of the next Medical Staff election, the nominating committee consisting of the Medical Staff Officers shall convene. The nominating committee shall prepare a slate of nominees for Secretary/Treasurer to be filled at that election. The nominations shall be presented by the nominating committee and by the floor if any other nominations are presented, at every other annual meeting. The candidate who receives a majority vote of those Medical Staff members eligible to vote and present at the meeting at the time the vote is taken, shall be elected. In any election, if there are three or more candidates and no candidate receives a majority there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one candidate. The vote shall be by written secret ballot. Officers terms are effective from the start of the next Medical Staff year for a term of two years or until an officer's successor takes his place. At the end of each term, the Secretary/Treasurer shall take the position of Vice Chief of Staff and the Vice Chief of Staff will take the position of the Chief of Staff. If for any reason an officer does not complete that officer's term, each officer below that individual will advance to the next level of office and an election of a new Secretary/Treasurer will be held pursuant to the above procedures.

9.1-3 CHIEF OF STAFF

The Chief of Staff shall serve as the Chief Officer of the Medical Staff. The duties of the Chief of Staff shall include but not be limited to:

- (a) enforcing the Medical Staff Bylaw, Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
- (b) calling, presiding at and being responsible for the agenda at all meetings of the Medical Staff;
- (c) serving as a Chairperson of the Executive Committee;
- (d) interacting with the CEO and the Board of Directors in all matters of mutual concern with the Hospital;

- (e) appointing in consultation with the Executive Committee, members for all standing committees, and special Medical Staff liaison or multi-disciplinary committees, except where otherwise provided by these Bylaws;
- (f) representing the views and policies of the Medical Staff to the Board of Directors and to the CEO;
- (g) being a spokesperson for the Medical Staff and external professional and public relations;
- (h) performing such other functions as may be assigned to the Chief of Staff by these Bylaws, by the Medical Staff or by the Executive Committee;
- (i) serving on liaison committees with the Board of Directors and CEO as well as outside licensing accreditation agencies;
- (j) receiving and interpreting the policies of the Board of Directors to the Medical Staff;
- (k) be a member of the Medical Staff Development Committee;
- (l) the CEO and Chief of Staff are ex-officio of all Medical Staff meetings or may designate someone else to attend; and
- (m) intervene as necessary when patient care is threatened by failure of a Medical Staff member to respond to an emergency.

9.1-4 VICE CHIEF OF STAFF

The Vice Chief of Staff shall:

- (a) assume all duties and have any authority of the Chief of Staff in the event of the Chief of Staff's temporary inability to perform due to illness, being out of the community, or being unavailable for any other reason;
- (b) be a member of the Medical Staff Development Committee;
- (c) be a member of the Executive Committee;
- (d) succeed the Chief of Staff when the Chief of Staff fails to serve for any reason during his term of office; and
- (e) perform such duties as are assigned him by the present Chief of Staff.

9.1-5 TEMPORARY SUBSTITUTION

Should both the Chief of Staff and Vice Chief of Staff be unavailable during an emergency, the authority and duties of the Chief of Staff shall be temporarily assumed by

the Secretary/Treasurer, the Chair of the Division of Medicine, or the Chair of the Division of Surgery, in that order of succession.

9.1-6 SECRETARY/TREASURER

The Secretary/Treasurer shall:

- (a) be a member of the Executive Committee and Medical Staff Development Committee; and
- (b) perform such other duties as normally pertain to the office.

9.1-7 REMOVAL OF OFFICERS

The aforementioned officers may be removed by the Medical Staff, by a two-thirds majority vote of those present. Removal of any Medical Staff Officer may be recommended if he is suffering from physical or mental infirmity that renders him incapable of fulfilling the duties of his office. Notice of any meeting of which such action may be taken shall be given in writing to such officer at least ten days prior to the date of such meeting. The officer shall be afforded the opportunity to speak in his own behalf before the Executive Committee of the Medical Staff prior to the taking of any vote on his removal. Such removal will be effective when approved by a two-thirds majority vote of those present.

9.2 VACANCIES IN OFFICE

Upon vacancy in the office of the Chief of Staff prior to the expiration of his term, the Vice Chief of Staff shall assume the duties and authority of the Chief of Staff for the remainder of the unexpired term. If there is a vacancy in any other office, the Executive Committee shall appoint another Active Staff appointee to serve out the remainder of the unexpired term. Such appointment will be effective immediately.

9.3 MEETINGS OF THE MEDICAL STAFF

9.3-1 REGULAR STAFF MEETINGS

The Medical Staff shall meet at least two times a year, on dates set at the beginning of the Medical Staff year by the Chief of Staff, for the purpose of review of Executive Committee reports, minutes and recommendations and to act on any other matters based on the agenda by the Chief of Staff. The meeting held closest to the end of the Medical Staff year shall be the annual meeting.

9.3-2 SPECIAL STAFF MEETING

Special Meetings of the Medical Staff may be called at any time by the Chief of Staff, the majority of the Executive Committee or by a petition signed by not less than ten (10) active Medical Staff members. On behalf of the Board of Directors, or Chief Executive Officer, the Chief of Staff may also call a special meeting. No business shall be

transacted at any special meeting except that stated business listed in the notice calling the meeting.

9.3-3 NOTICE OF MEETINGS

A written or email notice stating the place, day, hour and purpose of any meeting of the Medical Staff shall be mailed or emailed to or placed in the Medical Staff mail room box of each Medical Staff member eligible to vote. Such notice may not be less than five days before the date of such meeting and shall be posted in the Hospital as required by these Bylaws. The notice of meeting shall be deemed delivered when emailed or deposited in the United States mail or the Medical Staff mail room box addressed to each member of the Medical Staff.

9.3-4 QUORUM

Persons present and eligible to vote at any regular or special meeting of the Medical Staff shall constitute a quorum.

9.3-5 ATTENDANCE

Attendance at four general Medical Staff meetings during a reappointment period will waive the reappointment fee. Credit will be given for excused absences submitted to the Executive Committee.

9.4 MEDICAL STAFF STRUCTURE IN CLINICAL DEPARTMENTS

Each Medical Staff member will be required to belong to a clinical department which is related to the majority of the type of medical practice. Furthermore, these departments will be grouped together into two divisions, Surgical Division and the Medicine Division.

9.4-1 SURGICAL DIVISION

The Surgical Division will include the four departments; surgery, pathology, anesthesia and obstetrics/gynecology. The surgery department will include general surgery and the surgical subspecialties.

9.4-2 MEDICINE DIVISION

The Medicine Division will include the six departments of medicine, radiology, emergency medicine, family practice, hospitalist, and pediatrics. The medicine department will include general medicine and the medical subspecialties.

9.4-3 DIVISION CHAIR

- (a) Each division shall elect its own Chair by a simple majority of ballots cast by eligible voters for a two year term. The Chair will be approved by the Executive Committee and may be removed by the Division only by a two-thirds majority vote of the membership of that Division.

(b) DUTIES

The Division Chair is responsible for all clinically and administratively related activities of the division, unless otherwise provided for by the Hospital.

9.4-4 DEPARTMENT CHAIR

- (a) Each department shall elect its own leader by a simple majority of ballots cast by eligible voters for a two year term. The individual chosen for this role must either be certified by an appropriate specialty board or have comparable competence affirmatively established through the credentialing process.
- (b) The Department Chair reports to the Division and to the Division Chair on all professional activities within the Department. The roles and responsibilities of the Department Chair include the following:
- (1) Oversee the clinically related activities of the Department.
 - (2) Oversee the administratively related activities of the Department, unless otherwise provided by the Hospital.
 - (3) Perform continuing surveillance of the professional performance of all individuals in the Department who have delineated Clinical Privileges. Use the Ongoing Professional Practitioner Evaluation to identify a Practitioner's professional practice trends that impact on quality of care and patient safety. This Ongoing Professional Practitioner Evaluation information will be factored into the recommendation to maintain, revise, or revoke existing Privileges.
 - (4) Recommend to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the Department.
 - (5) Recommending Clinical Privileges for each member of the department.
 - (6) Assess and recommend to the Chief of Staff off-site sources for needed patient care, treatment, and services not provided by the Department or the Hospital.
 - (7) Integrate the Department into the primary functions of the Hospital.
 - (8) Coordinate and integrate interdepartmental and intradepartmental services.
 - (9) Develop and implement policies and procedures that guide and support the provision of care, treatment, and services.
 - (10) Make recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

- (11) Perform continuous assessment and improvement of the quality of care, treatment, and services.
- (12) Maintain quality control programs, as appropriate.
- (13) Ensure orientation and continuing education of all Department members.
- (14) Recommend space and other resources needed by the Department.
- (15) The Department may develop rules and regulations and establish its own criteria for the conduct of its Department. This includes, but is not limited to setting criteria for education and proficiency in clinical performance and establishing a clearly defined process that facilitates the evaluation of each Practitioner's professional practice and the type of data to be collected for approval by the Medical Staff.

CHAPTER 10 COMMITTEES OF THE MEDICAL STAFF

10.1 CHAIR

10.1-1 Appointment of all committee chairs, unless otherwise provided for in these Bylaws, will be approved by the Board upon receiving recommendations from the Chief of Staff. All chairs shall be selected from among persons appointed to the Active Staff.

10.1.2 Such appointments will be for an initial term of two (2) years. After serving an initial term a chair may be reappointed by the Chief of Staff from term to term.

10.2 MEMBERS

10.2-1 Members of each committee, except as otherwise provided for in these Bylaws, shall be appointed yearly by the Chief of Staff, with no limitation in the number of terms they may serve; provided, however, members of the Credentials Committee serve for a five year term. All members appointed by the Chief of Staff may be removed and vacancies filled by the Chief of Staff at his discretion.

10.2-2 The CEO and the Chief of Staff or their respective designees shall be members, ex-officio without vote, on all committees.

10.3 MEETINGS, REPORTS AND RECOMMENDATIONS

10.3-1 Unless otherwise specified in these Bylaws or in a resolution authorizing a committee, all committees shall meet at least quarterly, maintain a permanent record of its findings, proceedings and actions and make a report thereof to the Executive Committee and the Chief Executive Officer.

10.3-2 Each committee shall report (with or without recommendation) to the Executive Committee for its consideration and appropriate action any situation involving significant questions of clinical competence, patient care and treatment, case management, professional ethics, infraction of Hospital or Medical Staff Bylaws or Rules and Regulations or unacceptable conduct on the part of any individual appointed to the Medical Staff.

10.3-3 Copies of the reports required by Sections 10.3-1 and 10.3-2 above shall be forwarded to the Department Chair in which the affected individual exercises his primary Clinical Privileges.

10.4 EXECUTIVE COMMITTEE

(a) The Executive Committee will be composed of the following members: Chief of Staff, the Vice-Chief of Staff, the Secretary/Treasurer, the immediate past Chief of Staff, the Chair of the Division of Medicine, the Chair of the Division of Surgery, the Chair of the Credentials Committee, the Chair of the Peer Review Committee, and a Wyoming Family Practice Residency Program Representative.

The CEO or his designee attends each Executive Committee meeting. The CEO or his designee shall be an ex-officio member. Department Chairs may attend and vote but are not required to attend. A quorum is determined by the number of members present.

(b) REMOVAL

A member of the Executive Committee may be removed from the committee by the Medical Staff, by a two-thirds majority vote of those present.

(c) DUTIES

The duties of the Executive Committee shall be to:

- (1) represent and to act on behalf of the Medical Staff in all matters between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws;
- (2) coordinate the activities and general policies of the various departments;
- (3) receive and act upon committee reports, and to make recommendations concerning them to the CEO and the Board;
- (4) implement policies of the Medical Staff which are not the responsibility of the departments;
- (5) provide liaison among Medical Staff, the CEO and the Board;
- (6) recommend action to the CEO on matters of a medical-administrative and Hospital management nature;
- (7) ensure that the Medical Staff is kept abreast of all regulatory and accreditation requirements applicable to the Medical Staff;
- (8) take steps to ensure the enforcement of Hospital and Medical Staff rules in the interest of patient care and of the Hospital on the part of all persons who hold appointment to the Medical Staff;
- (9) make recommendations to the Board on actions described in Chapter 11 of these Bylaws;
- (10) review recommendations from the Credentials Committee regarding applicants for appointment, reappointment, and Clinical Privileges and to comment, when appropriate, to the Board thereon;
- (11) be involved with the Board in setting policies for the general quality of medical care rendered to patients in the Hospital;

- (12) review the Bylaws, Rules and Regulations of the Medical Staff as needed and recommend such changes thereto as may be necessary or desirable; and
- (13) order a health examination for cause at any time a Practitioner's fitness is in question. The examiner should be mutually acceptable by the Executive Committee and the Practitioner. In the event a mutually acceptable examiner cannot be agreed upon, then an examiner will be selected by the Wyoming Board of Medicine. The examiner shall provide to the Executive Committee only such information or opinion as is pertinent to the specific cause which triggered the examination. The cost of the examination should be borne by Wyoming Medical Center.

In any instance where a member of the Executive Committee has a conflict of interest in any matter involving another Medical Staff appointee which comes before the Executive Committee, or in any instance where a member of the Executive Committee brought the complaint against that appointee, that member shall not participate in the discussion or voting on the matter and shall absent himself from the meeting during that time, although he may be asked to answer any questions concerning the matter before leaving.

The Chair of the Executive Committee, his representative and such members of this committee as may be necessary shall be available to meet with the Board or its applicable committee on all recommendations that the Executive Committee may make.

10.5 CREDENTIALS COMMITTEE

10.5-1 COMPOSITION

The Credentials Committee shall consist of five (5) members of the Active Medical Staff. The Vice Chief of Staff shall be an ex-officio member of the Credentials Committee. The appointed members shall each serve a term of appointment of five (5) years. Appointment to the Credentials Committee shall be subject to the approval of the Executive Committee and the Board of Directors. Service on this Committee shall be considered as the primary Medical Staff obligation of each appointed member, and other Medical Staff duties shall not interfere, nor shall these members be overly burdened with additional Medical Staff assignments.

10.5-2 DUTIES

The duties of the Credentials Committee shall be to:

- (a) review the credentials of all applicants for Medical Staff appointment, reappointment, and Clinical Privileges, to make investigations of and to interview such applicants as may be necessary, and to make a report of its findings and recommendations to the Executive Committee for approval;

- (b) review the credentials of all applicants who request to practice at the Hospital as Allied Health Professionals, to make investigations of and interview such applicants as may be necessary, and to make a report of its findings and recommendations to the Executive Committee for approval;
- (c) review and to investigate when appropriate, as questions arise, all information available regarding the clinical competence, behavior, or other questions of competence (as described in the Bylaws, Rules and Regulations, or Policies of the Medical Staff or the Hospital) of persons currently appointed to the Medical Staff and of those practicing as Allied Health Professionals, and, as a result of such review and investigation, to make a report of its findings and recommendations to the Executive Committee for approval;
- (d) undertake a review and/or an investigation, as described above, when requested by the Executive Committee, by the officers of the Medical Staff, by any Medical Staff member, by the CEO or by the Board of Directors;
- (e) perform ongoing review of the Medical Staff Bylaws, Rules and Regulations, and Policies of the Medical Staff as they regard appointment, reappointment, Clinical Privileges, as well as hearings as described in these Bylaws;
- (f) the Chair of the Credentials Committee, his designee, or such members of the Committee as are deemed necessary shall be available to meet with the Executive Committee, or with the Board or its applicable committee, on all recommendations that the Credentials Committee may make; and
- (g) meet as often as necessary to accomplish its duties, but at least six (6) times a year and shall maintain a permanent record of its proceedings and actions.

In any instance where a member of the Credentials Committee has a conflict of interest in any matter involving an applicant or appointee to the Medical Staff which comes before the Credentials Committee, that member shall not participate in the discussion or voting on the matter and shall absent himself from the meeting during that time, although he may be asked to answer any questions concerning the matter before leaving.

10.6 PEER REVIEW COMMITTEE

10.6-1 COMPOSITION

The composition of the Peer Review Committee shall be in accordance with the Hospital's Peer Review Plan.

10.6-2 DUTIES

The primary duties are to monitor the current clinical competence of department members. As Department Chairs, they are responsible for recommending appropriate

credentialing for each department member and for developing minimum Privilege criteria. This committee will review Practitioner specific information.

- (a) Chart Review. Practitioner specific quality indicators and chart review information will be reviewed by the Department Chairs.
- (b) Identify cases for educational conferences. Cases that present good opportunities for an educational conference or Morbidity/Mortality conferences will be suggested to the Education Committee.
- (c) Identify opportunities for system improvement for the Hospital's Quality and Safety Coordinating Council. Cases that present cross-departmental issues will be discussed and process improvements suggested to the Hospital's Quality and Safety Coordinating Council and/or the Medical Executive Committee.
- (d) Assist in credentialing process. The Peer Review Committee will identify, intervene, educate, and monitor quality of care by an individual Practitioner, including conducting routine FPPEs of individual Practitioners.

10.7 CREATION OF STANDING COMMITTEES

The Executive Committee may, by resolution, and upon approval by the Board, without amendment of these Bylaws, establish a committee to perform one or more Medical Staff functions. In the same manner, the Executive Committee may by resolution dissolve or rearrange these committee structures, duties or composition as needed, to better perform the Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to a standing or special committee shall be performed by the Executive Committee.

10.8 SPECIAL COMMITTEES

Special Committees shall be created and their members and chairs shall be appointed by the Chief of Staff as required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Executive Committee.

CHAPTER 11 CORRECTIVE ACTION

11.1 CORRECTIVE ACTION

For the purpose of these Bylaws, any corrective action must be taken (1) in the reasonable belief that the action is in the furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures as described in these Bylaws are afforded to the member or after such other procedures as are fair to the member under the circumstances; (4) in the reasonable belief that the action was warranted by the facts known after a reasonable effort to obtain the facts and (5) after complying with the foregoing requirements of this paragraph.

11.1-1 CRITERIA FOR INITIATION

Any person may provide information to the Department Chairs, a member of the Executive Committee, or the CEO about the conduct, performance, or competence of a Medical Staff member.

- (a) Reports regarding Disruptive or Inappropriate Conduct. When reliable information indicates a member may have engaged in disruptive or inappropriate conduct, the procedures under the Principles of Partnership may apply and be initiated as set out in the Principles of Partnership Conduct Reporting Policy. The Board of Directors and Medical Staff have adopted the Principles of Partnership Policy to affirm, along with Hospital employees, their mutual responsibility to work together in an ongoing, positive, and dynamic process with the goal of high quality healthcare at the Hospital. The Policy contains procedural steps that may be used to address situations in which Medical Staff and Hospital employees experience conflict.

As provided in the Principles of Partnership, if these procedures fail to resolve the issue or, at any time, it is determined that the conduct is severe, egregious, or inappropriate, such as when the safety of patients or otherwise is jeopardized, the matter may be referred in writing to the Medical Executive Committee for additional action. Additionally, notwithstanding the above, the procedures in the Principles of Partnership do not supersede the process of Summary Suspension as outlined in Section 11.2 of these Bylaws for the unusual situation in which conduct appears to require immediate action be taken to protect the life or well-being of patient.

There is no requirement that the Principles of Partnership processes are used in lieu of or prior to the processes outlined in the Peer Review Policy or this Section 11.1.

- (b) Reports regarding Patient Safety, Quality of Care, Ethics, Professional Standards, and Compliance with Policy. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) unethical; (3) contrary to the Medical Staff Bylaws, rules or regulations, or

Wyoming Medical Center Principles of Partnership; or (4) below applicable professional standards, a request for an FPPE or action against such member may be initiated by the Chief of Staff, a Department Chair, or the Executive Committee.

11.1-2 INITIATION

Any referral or request for corrective action or FPPE, whether based on behavior or professional competence, should be submitted in writing to the Executive Committee, and supported by reference to specific activities or conduct alleged. If the Executive Committee initiates a corrective action or FPPE, it shall make an appropriate record of the reasons.

11.1-3 FOCUSED PROFESSIONAL PRACTICE EVALUATION

If the Executive Committee concludes an FPPE is warranted, it shall direct in writing for a time-limited FPPE to be undertaken during which there is an evaluation of the Practitioner. , If the physician resigns prior to completion of the FPPE and the FPPE is for issues related to a Practitioner's professional competence or conduct, a Data Bank report may be necessary, because the National Practitioner Data Bank requires that the surrender of Clinical Privileges while under an investigation for professional conduct or competence be reported.the The Executive Committee shall assign the task to an appropriate Medical Staff officer, Medical Staff department, or standing or ad hoc committee of the Medical Staff. The relevant Department Chair or designee will be involved in the FPPE. The Executive Committee in its discretion may appoint Practitioners who are not members of the Medical Staff as temporary members of the Medical Staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these Practitioners temporary Clinical Privileges under Section 6.3, should circumstances warrant. When the FPPE is delegated to an officer or committee, such officer or committee shall proceed with the FPPE in a prompt manner and shall forward a written report of the FPPE to the Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an FPPE is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the evaluating body deems appropriate. The FPPE shall not constitute a "hearing" as that term is used in these Bylaws, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any FPPE, at all times the Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the evaluating process, or other action.

11.1-4 EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the FPPE period, the Executive Committee shall take action which may include, without limitation:

- (a) determining no corrective action be taken, if the Executive Committee determines there was no credible evidence for the complaint in the first instance;

- (b) deferring action for a reasonable time where circumstances warrant;
- (c) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department heads from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;
- (d) recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for admission, mandatory consultation, or monitoring;
- (e) recommending reduction, modification, suspension or revocation of Clinical Privileges;
- (f) recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
- (g) recommending suspension, revocation or probation of Medical Staff membership; and
- (h) taking other actions deemed appropriate under the circumstances.

11.1-5 SUBSEQUENT ACTION

- (a) If corrective action as set forth in Section 11.1 is recommended by the Executive Committee, that recommendation shall be transmitted to the Board of Directors.
- (b) The recommendation of the Executive Committee shall be forwarded for review by the Board of Directors as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Chapter 12. The Board's approval of the Executive Committee's recommendation will not be unreasonably withheld. If it appears likely that the Board will not follow the Executive Committee's recommendations, then a meeting between representatives of the Board and Executive Committee will occur to discuss the matter.

11.2 SUMMARY RESTRICTION OR SUSPENSION

11.2-1 CRITERIA FOR INITIATION

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient, the Chief of Staff, the Executive Committee, or the Department Chair or designee in which the member holds Privileges may summarily restrict or suspend the Medical Staff membership or Clinical Privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly be given written notice from the Executive Committee. In addition, the affected Medical Staff

member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 11.2-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the Department Chair or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member. When there is a summary suspension, no professional review action by a professional review body occurs until completion or waiver by the affected Practitioner of all of the procedures and appeals set forth in these Bylaws.

11.2-2 WRITTEN NOTICE OF SUMMARY SUSPENSION

Within one working day of imposition of a summary suspension, the affected Medical Staff member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the Practitioner's Privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 12.3-1 (which applies in all cases where the Executive Committee does not immediately terminate the summary suspension). The notice under Section 12.3-1 may supplement the initial notice provided under this section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

11.2-3 EXECUTIVE COMMITTEE ACTION

Within seven (7) days after such summary restriction or suspension has been imposed, a meeting of the Executive Committee [or a subcommittee appointed by the Chief of Staff] shall be convened to review and consider the action. Upon request of the member or the committee, the member shall attend and make a statement concerning the issues of the FPPE, on such terms and conditions as the Executive Committee may impose, although in no event shall any meeting of the Executive Committee, with or without the member, constitute a "hearing" within the meaning of these Bylaws, nor shall any procedural rules apply. The Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event, it shall furnish the member with notice of its decision within two (2) working days of the meeting.

11.2-4 PROCEDURAL RIGHTS

Unless the Executive Committee promptly terminates the summary restriction or suspension, the member shall be entitled to the procedural rights afforded by Chapter 12 to be concluded within thirty (30) days.

11.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's Privileges or membership may be suspended or limited as described.

11.3-1 LICENSURE

(a) REVOCATION AND SUSPENSION

Whenever a member's license or other legal credential authorizing practice in the State of Wyoming expires, is revoked, or is suspended, Medical Staff Clinical Privileges shall be automatically revoked as of the date such action became effective.

(b) RESTRICTION

Whenever a Practitioner practicing in the State of Wyoming is limited or restricted by the applicable licensing or certifying authority, any Clinical Privileges which the member has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) PROBATION

Whenever a member is placed on probation by the applicable licensing or certifying authority, his membership status and Clinical Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

11.3-2 CONTROLLED SUBSTANCES

(a) REVOCATION, LIMITATION OR SUSPENSION

Whenever a member's DEA certificate or Wyoming Board of Pharmacy number expires or is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such change becomes effective and throughout the term until the DEA certificate or Wyoming Board of Pharmacy number is reinstated.

(b) PROBATION

Whenever a member's DEA certificate or Wyoming Board of Pharmacy number is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date of probation.

11.3-3 FAILURE TO SATISFY SPECIAL ATTENDANCE REQUIREMENT

Failure of a member without good cause to appear and satisfy the requirements of Special Attendance shall be a basis for corrective action. Special Attendance notice will be provided ten (10) working days prior to meetings and shall include time and place of the meeting and a general indication of the issue involved.

11.3-4 FAILURE TO COMPLETE MEDICAL RECORDS

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Executive Committee. Medical records that lack appropriate content will be considered incomplete for purposes of this Section. The history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but before surgery or a procedure requiring anesthesia services. A limited suspension in the form of withdrawal of admitting and other related Privileges until medical records are completed, may be imposed by the Chief of Staff, or his or her designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, “related Privileges” means voluntary on call service for the emergency room, scheduling surgery, consulting on Hospital cases, providing inpatient coverage for colleagues and providing professional services within the Hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Executive Committee. Members whose Privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff or his or her designee.

11.3-5 FAILURE TO ATTEND MEETINGS

Failure to attend meetings as required in these Bylaws and as defined by policy shall be considered a voluntary relinquishment of Medical Staff appointment and shall be sufficient grounds for refusing to reappoint the individual concerned. Such failures shall be documented and specifically considered by the Credentials Committee when making its recommendations for reappointment and by the Board when making its final decisions.

11.3-6 FAILURE TO ATTEND ER

Any Practitioner who refuses to respond to an emergency department call when the Practitioner’s name makes him eligible for call may be reported by the Department Chair of Emergency Medicine and to the Executive Committee. The Executive Committee may discuss the situation with the Practitioner and may deny him the Privilege of admitting patients for a period not to exceed thirty (30) days, if the failure to respond to an emergency call is not justified in the opinion of the Executive Committee.

11.3-7 WELL BEING

A change in the behavior or health status of a member that jeopardizes the member’s ability to carry out his delineated Clinical Privileges with good quality shall be subject to the Well Being of the Medical Staff Policy of the Hospital. Examples of such change

include depression, deterioration through the aging process, loss of motor skills, stress, burn out, substance abuse/dependence, and psychological problems.

11.3-8 PROFESSIONAL LIABILITY INSURANCE

Whenever a member's professional liability insurance expires or otherwise fails to meet minimum requirements for professional liability insurance coverage as prescribed by the Board, Medical Staff Clinical Privileges shall be automatically suspended as of the date such action became effective. The suspension shall continue until lifted by the Chief of Staff or his or her designee.

11.3-9 FAILURE TO MAINTAIN CURRENT VACCINATIONS/IMMUNIZATIONS

Whenever a member fails to timely meet requirements to provide documentation of current vaccinations as required by Hospital employee policies, including annual flu vaccinations required by the Hospitals' Influenza Policy, Medical Staff Clinical Privileges shall be automatically suspended effective the day after the documentation was due. The suspension shall continue until lifted by the Chief of Staff or his or her designee.

11.4 CONTINUITY OF PATIENT CARE

Upon the imposition of summary suspension or the occurrence of an automatic suspension, the Chief of Staff or the Department Chair for the Department to which the suspended Practitioner is assigned, shall provide for alternative coverage for the suspended Practitioner's patients in the Hospital. The wishes of the patient shall be considered, when feasible, in choosing a substitute Practitioner. The suspended Practitioner shall confer with the substitute Practitioner to the extent necessary to safeguard the patient.

11.5 RELATED PRIVILEGES

Within Section 11, "related Privileges" means voluntary on call service for the emergency room, scheduling surgery, consulting on Hospital cases, providing inpatient coverage for colleagues and providing professional services within the Hospital for future patients.

CHAPTER 12 HEARINGS AND APPELLATE REVIEWS

These hearing requirements are applicable to all members of the Medical Staff but do not apply to Allied Health Professionals.

12.1 GENERAL PROVISIONS

12.1-1 INTERVIEWS

The Medical Executive Committee or the Board may afford an interview to a member if it is considering recommending an adverse action. The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The member shall be informed of the general nature of the circumstances and may present any relevant information. An informal record of any interview shall be made but shall not be admissible in any hearing proceeding or other forum.

12.1-2 EXHAUSTION OF REMEDIES

If adverse action described in these *Bylaws* is taken or recommended, the applicant or member must exhaust the remedies afforded by these *Bylaws* before resorting to legal action.

12.1-3 APPLICATION OF CHAPTER

For purposes of this Chapter, the term “member” may include “applicant”, as it may be applicable under the circumstances, unless otherwise stated. All references to the “Chief Executive Officer” include his or her designee.

12.1-4 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

12.1-5 FINAL ACTION

Recommended adverse actions described in Section 12.2-1 shall become final only after the hearings and appellate rights set forth in these *Bylaws* have either been exhausted or waived.

12.2 GROUNDS FOR HEARING

12.2-1 Any one or more of the following actions or recommended actions shall be deemed an actual or potential adverse action and constitute grounds for a hearing:

- (a) denial of Medical Staff membership;
- (b) denial of requested advancement in Medical Staff membership status, or category;
- (c) denial of Medical Staff reappointment;

- (d) change in Medical Staff category which results in a loss of prerogatives or impacts Clinical Privileges;
- (e) suspension of Medical Staff membership;
- (f) revocation of Medical Staff membership;
- (g) denial of requested Clinical Privileges;
- (h) involuntary reduction of current Clinical Privileges;
- (i) suspension of Clinical Privileges;
- (j) termination of all Clinical Privileges; or
- (k) involuntary imposition of significant consultation requirements.

12.2-2 Recommended actions that do not constitute grounds for a reportable formal hearing include, but are not limited to:

- (a) Appointment of an FPPE Committee;
- (b) The performance of an FPPE or other type of evaluation of any matter;
- (c) The formulation and presentation of any preliminary report of any FPPE Committee to the Medical Executive Committee or CEO of the Hospital;
- (d) The making of a request or issuance of a directive to an applicant or Medical Staff member to appear at an interview or conference before the Credentials Committee, any Ad Hoc FPPE Committee, the Peer Review Committee, the Medical Executive Committee, the Board of Directors, or the CEO of the Hospital in connection with any FPPE before a proposed adverse recommendation or action;
- (e) The denial of or refusal to accept an application to the Medical Staff or request for privileges for initial appointment or reappointment where the application is incomplete, where the eligibility threshold requirements are not met, or where the application is not accepted because the Hospital has a closed department or an exclusive contract in the area in which the applicant or Medical Staff member is requesting Clinical Privileges;
- (f) Any reduction, termination, or other impact on Clinical Privileges as a result of a Hospital decision to form, eliminate, or close a department or services including when such action is taken in relation to an exclusive contract.
- (g) The denial or revocation of Temporary Privileges;
- (h) The automatic suspension or limitation of Clinical Privileges under Section 11.3 of the Medical Staff bylaws;

- (i) The imposition of supervision or observation on a Medical Staff member which supervision or observation does not restrict the Clinical Privileges of the Medical Staff member or the delivery of professional services to patients;
- (j) The issuance of a letter of warning, admonition or reprimand;
- (k) A recommendation that the Medical Staff member be directed to obtain retraining, additional training, or continuing education;
- (l) The following changes in Medical Staff category: (i) a change from active staff to consulting staff for failure to live close enough to the Hospital or failure to regularly admit or care for patients in Hospital; or (ii) any other change in category or Clinical Privileges resulting from the failure of a Medical Staff member to meet the criteria for a specific category;
- (m) Concurrent or retrospective proctoring that does not restrict the Clinical Privileges of any individual member or the delivery of professional services to patients;
- (n) Any recommendation or action not “adversely affecting” (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act) any Medical Staff member;
- (o) Corrective counseling;
- (p) Imposition of requirement for physical or mental exam;

12.3 INITIATION OF HEARING

12.3-1 NOTICE OF ADVERSE ACTION

A Practitioner against whom adverse action has been taken or recommended shall promptly be given special notice of such action or recommendation by the Chief Executive Officer. The notice shall state (1) the reasons for the action or recommendation in sufficient detail so that the Practitioner can prepare a defense, (2) that the Practitioner has the right to request a hearing, (3) that the request for hearing must be submitted in writing within 30 days of the date of the notice, (4) that the failure to timely request a hearing waives the Practitioner’s right to a hearing or further review of the action, and (5) a summary of the Practitioner’s rights concerning the hearing referring to Section 12.5.

12.3-2 REQUEST FOR HEARING

A Practitioner shall have 30 days following the date of the notice of adverse action to deliver a written request for a hearing. Such request shall be delivered to the Chief Executive Officer, either in person or by certified or registered mail. The request for a hearing shall include a detailed statement of the Practitioner’s position as to each reason listed in the notice for the proposed adverse action, in sufficient detail to clearly indicate the basis for any disagreement Practitioner may have with the findings or

recommendations of the Medical Executive Committee or the Board. If the Practitioner fails to comply with this requirement within 7 days after written notice of this failure from the Chief Executive Officer, the Practitioner will be deemed not to have filed a request for a hearing.

12.4 HEARING REQUIREMENTS

12.4-1 NOTICE OF HEARING.

- (a) Within 20 days after receipt of the request for a hearing, or as soon as practical thereafter, the Chief of Staff shall appoint the members of the Hearing Committee or the arbitrator, set the date, time, and place of the hearing, and give the Practitioner notice of the date, time, and place of the hearing. The notice must be given at least 30, but not more than 60, days before the date of the hearing.
- (b) The notice of hearing shall contain a concise statement of the Practitioner's alleged acts or omissions, or the other facts or information on which the proposed adverse action is based, a copy of the exhibits expected to be presented at the hearing, a list of witnesses expected to be called at the hearing, and the names of the members of the Hearing Committee. The Chief of Staff may supplement the statement, add exhibits and add witnesses, so long as such supplemental information is provided at least 10 days before the hearing.

12.4-2 HEARING COMMITTEE

- (a) The Hearing Committee shall be composed of either (1) three members who are qualified per Section 12.4-2(b) or (2) if only non-clinical issues are involved, one arbitrator who is selected per Section 12.4-2(c).
- (b) To be qualified to serve on the Hearing Committee, a member shall not have actively participated in formulating the adverse recommendation or action that occasioned the hearing, or in initiating or investigating the underlying matter at issue at any earlier stage of the proceedings, and shall not be in direct economic competition with the Practitioner. The Hearing Committee member shall not be professionally associated with the Practitioner except as a result of both the Practitioner and Hearing Committee member being employees or members of the Medical Staff of the Hospital.
- (c) If an arbitrator is used, he shall be a non-physician who (1) is either an attorney or retired judge and (2) has experience in arbitration. The arbitrator shall be mutually acceptable to the Practitioner and the Chief of Staff. The cost of the arbitrator will be paid for by the Hospital.
- (d) If the Practitioner believes that any Hearing Committee member or the hearing arbitrator is not qualified to serve, he shall notify the Chief of Staff in writing of his objection and the specific grounds for disqualification within 10 days after receipt of the notice of the hearing. Failure to object timely to the qualifications of a committee member or the arbitrator shall constitute the Practitioner's

agreement that the committee members are, and the arbitrator is, qualified and a waiver as to any ground for disqualification. The Chief of Staff may remove the committee member or the arbitrator, and appoint a replacement if he determines that the objection is justified. The Chief of Staff's decision shall be final and non-appealable.

- (e) Before the hearing, the Hearing Committee members shall refrain from discussing the matter among themselves, with the Practitioner, members of the Credentials Committee or the Medical Executive Committee, the Chief of Staff or other persons with knowledge of the case. Hearing Committee members may discuss procedural matters with the hearing officer, Chief of Staff or the attorney for the Hospital or Practitioner. The arbitrator may discuss procedural matters with the attorney for the Hospital or Practitioner. The Practitioner shall not contact or discuss the matter with any member of the Hearing Committee.

12.4-3 HEARING OFFICER

- (a) Either the Practitioner or the Chief of Staff may request that the presiding officer at the hearing be a hearing officer rather than a member of the Hearing Committee as long as the hearing officer meets the criteria set forth in Section 12.4-3(b). Such request must be made in writing and mailed or delivered to the Chief Executive Officer so that it is received not less than 15 days before the hearing date. Upon receipt of the request, the Chief Executive Officer shall select a hearing officer and notify the Practitioner and Chief of Staff of the name and address of the person selected. The Chief Executive Officer may select a hearing officer for the hearing, without a request from either party, if he deems it appropriate. This section does not apply if an arbitrator is used.
- (b) The hearing officer shall be an attorney, licensed to practice in Wyoming, with not less than five years of experience in (i) practice, (ii) service as a former judge or magistrate, (iii) dispute resolution mediation or arbitration proceedings or (iv) a combination of such experience.
- (c) The hearing officer shall have the duties of the presiding officer as set forth in Section 12.5-2, except that he shall not participate in the Hearing Committee's deliberations or vote. At the committee's request, the hearing officer shall be present during its deliberations and advise the committee on procedural, evidentiary, and legal matters.

12.5 HEARING PROCEDURE

12.5-1 PERSONAL PRESENCE

The personal presence of the Practitioner who requested the hearing is required. A Practitioner who fails without good cause to appear at such hearing shall be deemed to have waived his rights in the same manner and with the same consequence as provided in Section 12.9-2(a).

12.5-2 PRESIDING OFFICER

The presiding officer, or hearing officer if one is chosen, shall conduct the hearing, act to maintain decorum, and endeavor to assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence in an efficient and expeditious manner. He shall determine the procedure to be followed during the hearing and shall make all rulings on questions which pertain to matters of law, procedure, compliance with these Bylaws and the admissibility of evidence.

12.5-3 ARBITRATOR

If one arbitrator is selected in lieu of a Hearing Committee, all other procedures in this Chapter 12 will be followed and no hearing officer will be selected. The arbitrator will act in lieu of the Hearing Committee.

12.5-4 RIGHTS OF PARTIES

During the hearing, each of the parties shall have the following rights:

- (a) to make an opening and closing statement;
- (b) to call and examine witnesses;
- (c) to introduce exhibits;
- (d) to cross-examine any witness on any matter relevant to the issues;
- (e) to rebut the evidence;
- (f) to request that, in addition to the record which is made pursuant to § 3.07, a record of the hearing be made at the requesting party's expense by a certified shorthand reporter;
- (g) to obtain a copy of the hearing record upon request and payment of reasonable costs of preparation;
- (h) to submit a written statement at the close of the hearing; and
- (i) to be represented by an attorney or another person of the party.

12.5-5 PROCEDURE AND EVIDENCE.

- (a) At least 30 days before the hearing, the Practitioner shall provide to the presiding officer, or the hearing officer if one has been appointed, and to the Chief Executive Officer, a written list of the witnesses and a copy of the exhibits the Practitioner intends to present in his behalf and the name and address of his counsel or other person representing him. The Practitioner may supplement the list of witnesses and exhibits after receipt of supplemental information from the

Chief Executive Officer pursuant to Section 12.4-1(b), so long as he does so at least 5 days before the hearing.

- (b) The Practitioner, the Chief Executive Officer and the Medical Executive Committee shall be entitled to submit written statements concerning any issue of law or fact before or at the hearing. The statement shall be made part of the hearing record.
- (c) The hearing is part of the administrative review process designed for the sole purpose of maintaining or enhancing the quality of professional standards of conduct or competence, or both, and in the furtherance of quality health care. That character of the proceedings, as well as ensuring a fair hearing for the Practitioner, shall be preserved by the presiding officer. To those ends, the presiding officer may limit examination and cross-examination of witnesses, limit the length of opening and closing statements, limit the number of persons representing a party, and make such other rulings as he deems appropriate in connection with the hearing. Depositions, interrogatories, and requests for admissions shall not be permitted. Any requests for production of documents shall be limited to information that is relevant to the hearing issues. The hearing shall not be conducted according to technical rules relating to examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any rule of law which might make the admission of such evidence improper over objection in civil actions. Absent good cause, as determined by the presiding officer, neither the Practitioner nor the Chief Executive Officer may call any witness who was not listed nor introduce any document, a copy of which was not listed and furnished to the other party, as required by Section 12.5-5(a).
- (d) The presiding officer may require that oral evidence be taken only on oath or affirmation administered by the reporter.
- (e) By requesting a hearing, the Practitioner shall be deemed to have waived all rights of confidentiality in connection with evidence presented at the hearing and the information concerning him contained in the Hospital's Medical Staff files or obtained elsewhere. The Hearing Committee shall be entitled to consider any material contained on file in the Hospital, materials obtained from other health care facilities and all other information in connection with Practitioner's applications for appointment, reappointment or reinstatement to the Medical Staff; and for Clinical Privileges at health care facilities.
- (f) If the Practitioner who requested the hearing does not testify in his own behalf, he may be called and examined by the Medical Executive Committee or members of the Hearing Committee, or both, as if under cross-examination.

12.5-6 BURDEN OF PROOF

When a hearing involves denial of initial Medical Staff appointment, reinstatement, reappointment, or denial of requested Clinical Privileges, then the Practitioner who requested the hearing shall have the burden of proving, by a preponderance of the evidence, that the adverse recommendation or action lacks substantial factual basis, or that the adverse recommendation is arbitrary, unreasonable, or capricious. When a hearing involves an adverse recommendation for corrective action, the Medical Executive Committee shall have the initial obligation to present evidence reasonably supporting the recommended action, and the Practitioner shall thereafter be responsible for supporting his challenge to the adverse recommendation or action by presenting evidence that there is no substantial factual basis for the recommendation or proposed adverse action or that the recommendation or proposed adverse action is arbitrary, unreasonable, or capricious.

12.5-7 RECORD OF HEARING

A record of the hearing shall be made which is of sufficient detail and accuracy to assure that an informed and valid judgment can be made by any person or group that may later be called upon to review the record and render a recommendation or decision in the matter. The Chief Executive Officer may select the method for making the record, subject to approval by the presiding officer, which may be by certified shorthand reporter or electronic recording. The cost of making the record, but not preparing the transcript, shall be borne by the Hospital.

12.5-8 POSTPONEMENT

Requests for postponement of a hearing may be granted by the presiding officer, in his discretion, upon a showing of good cause.

12.5-9 RECESSES AND ADJOURNMENT

The Hearing Committee may recess and reconvene the hearing without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of the evidence, the hearing shall be closed. The Hearing Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties and their representatives. Upon the conclusion of its deliberations, which shall be not more than 10 days from conclusion of presentation of the evidence, the hearing shall be deemed finally adjourned. At no time before final adjournment, except during the hearing process, shall any Hearing Committee member discuss the merits of the case with any person other than the presiding officer.

12.5-10 HEARING COMMITTEE REPORT

Within 10 days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings, conclusions and recommendations and shall forward the report to the Medical Executive Committee for its consideration, with a copy to the Chief Executive Officer. At its next regularly scheduled meeting the Medical Executive Committee shall consider the Hearing Committee's report and may modify its recommendation and adopt a final Medical Executive Committee recommendation that

will promptly be forwarded to the Board. The Chief Executive Officer shall promptly send a copy of the Hearing Committee's report and any final Medical Executive Committee recommendation to the Practitioner and to the Board.

12.5-11 BOARD OF TRUSTEES

At its next regularly scheduled meeting, the Board shall consider the recommendation of the Medical Executive Committee and the Hearing Committee report and shall be guided by a reasonableness standard in determining whether it will accept, modify, or reject the recommendation of the Medical Executive Committee. The Board shall give notice of its decision promptly to the Practitioner, Medical Executive Committee, and Chief of Staff. If the Board's decision is adverse to the Practitioner, in the Board's notice to the Practitioner, the Practitioner shall be advised of the right to an appellate review as set forth in Section 12.6.

12.6 INITIATION OF APPELLATE REVIEW TO THE BOARD

12.6-1 REQUEST FOR APPELLATE REVIEW

If the Board's decision remains adverse to the Practitioner in any of the respects listed in this Chapter 12, the Practitioner may, within 10 days of the date of the notice, request an appellate review by the Board. The request shall be delivered to the Chief Executive Officer either in person or by certified or registered mail and shall state:

- (a) whether the Practitioner requests a copy of the hearing record, and if so, the Practitioner's commitment to share equally the cost of preparation of the record; and
- (b) whether the Practitioner wishes to present new or additional matters or evidence, and if so, what the new matters or evidence are, why they were not presented to the Hearing Committee, and why they are necessary to an adequate and fair review of the matter.

If the report and recommendation of the Hearing Committee is adverse to the previous recommendation of the Medical Executive Committee, the Medical Executive Committee may, within 10 days of the date of the Hearing Committee's report, request appellate review by the Board. The request shall be delivered to the Chief Executive Officer either in person, or by registered or certified mail, and shall state, in substance, the information described in a-b above.

12.6-2 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for appellate review, the Chief Executive Officer shall deliver such request to the Board and notify the presiding officer of the Hearing Committee and the Medical Executive Committee. The Board shall schedule and arrange for appellate review, which shall be no more than 60 days from the receipt of the appellate review request. At least 20 days before the appellate review, the Board through the Chief Executive Officer shall send the Practitioner and the presiding officer of the

Medical Executive Committee and the Hearing Committee special notice of the time, place and date of the review, and a copy of the hearing record if it was requested. The time for the appellate review may be extended by the appellate review body for good cause.

12.6-3 APPELLATE REVIEW BODY

The appellate review shall be conducted by the full Board or any odd number of Board members (no fewer than three individuals) designated by the presiding officer of the Board, with the presiding officer or his designee acting as presiding officer. The presiding officer shall determine the order of the proceedings, make all rulings concerning the proceedings, and shall maintain decorum during any oral presentation which may be permitted by the discretion of the Board under Section 12.7-4.

12.7 APPELLATE REVIEW PROCEDURE

12.7-1 NATURE OF PROCEEDINGS

The proceedings by the Appellate Review Body shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee and that committee's report. The Appellate Review Body shall also consider the written statements submitted pursuant to Section 12.7-2, and such other materials as may be presented and accepted under Section 12.7-5.

Appellate review means a determination by the Appellate Review Body of whether the recommendation of the MEC has a substantial factual basis and was reasonable. If requested, the Appellate Review Body shall also review whether the Practitioner received due process. If the Appellate Review Body determines the recommendation has a substantial factual basis and was reasonable, then the recommendation should ordinarily be affirmed. The Appellate Review Body should not substitute its judgment for that of the MEC.

12.7-2 WRITTEN STATEMENTS

The Practitioner seeking appellate review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he disagrees, and his reasons for such disagreement, at least 10 days before the scheduled date of the appellate review. The written statement may cover any matters raised at any step in the hearing process, and the Practitioner's representative may assist in the preparation. The statement shall be submitted to the Appellate Review Body through the Chief Executive Officer, who shall provide copies to the Medical Executive Committee. The committee may submit written responses, and if submitted, the Chief Executive Officer shall provide copies to the Practitioner, at least 2 days before the date of the appellate review. If the Medical Executive Committee seeks appellate review, the same type of procedure shall be followed.

12.7-3 APPELLATE REVIEW FACILITATOR

The Hospital may provide a person to advise the Appellate Review Body regarding issues that pertain to the appellate review procedure. The facilitator may, but need not, be the same person who acted as the hearing officer. If the person selected as the facilitator did not act as the hearing officer, it shall not be necessary for him to meet all of the requirements of a hearing officer as set forth in Section 12.4-3(b).

12.7-4 ORAL STATEMENT

Upon written request of a party contained in the written statement required by Section 12.7-2, or upon its own initiative, the Appellate Review Body, in its sole discretion, may allow or require the parties or their representatives to personally appear and make oral statements in support of their positions. Any party or representative appearing shall answer questions from any member of the Appellate Review Body. If the Appellate Review Body requires or permits oral statements, it may, in its sole discretion, require that a record of the oral statements be made in the manner described in Section 12.5-7.

12.7-5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

Presentation of new or additional matters or evidence not raised or presented during the original hearing or in the Hearing Committee's report, or not otherwise reflected in the record, shall be permitted only under unusual circumstances. The Appellate Review Body, in its sole discretion, shall determine whether the presentation of such matters or evidence shall be permitted.

12.7-6 RECESSES AND ADJOURNMENT

The Appellate Review Body may recess the review proceedings and reconvene them without additional notice, for the convenience of the participants or its members, for the purpose of obtaining new or additional evidence or consultation or for any purpose deemed appropriate by the members. Upon the conclusion of oral statement, if allowed, the appellate review shall be closed. The Appellate Review Body shall then, at a time convenient to itself; conduct its deliberations outside the presence of the parties or their representatives. Upon the conclusion of those deliberations, the appellate review shall be deemed finally adjourned.

12.7-7 ACTION TAKEN

The Appellate Review Body may affirm, modify, or reverse the adverse result or in its discretion, may refer the matter back to the MEC for further review and recommendation within 10 days and in accordance with its instructions. Within 10 days after adjournment or receipt of recommendation after referral back, the Appellate Review Body shall issue its written decision and transmit it to the Board.

12.8 FINAL DECISION OF THE BOARD

12.8-1 BOARD ACTION

No later than at its next regular meeting after (1) the Practitioner has waived his rights or the Medical Executive Committee has waived its rights under these Bylaws by failing to timely request a hearing or appellate review, or (2) the conclusion of the appellate review, the Board shall render its decision in the matter, unless that time is extended by the presiding officer or vice presiding officer of the Board to the following regular or special meeting. Such action shall constitute the final decision of the Board. The Board shall send notice of the final decision, including the basis for the decision, by notice to the Practitioner, to the presiding officer of the Hearing Committee and the Medical Executive Committee and to the Chief Executive Officer.

12.8-2 ARBITRATION FOLLOWING APPELLATE REVIEW PROCEDURE

Following completion of the appellate review procedure and final decision by the Board, all claims, controversies, and disputes, including without limitation, anti-trust and tort claims arising out of or relating to (a) any adverse action, (b) any report, recommendation, or action by any person or committee initiating corrective action, by a Department Chief, by the Credentials Committee, by the Medical Executive Committee, or by the Hearing Committee, (c) any decision by an Appellate Review Body, or (d) any interpretation or matter arising out of or relating to the Bylaws shall be settled solely by arbitration in Casper, Wyoming, in accordance with the rules of procedure for arbitration of the American Health Lawyers Association Alternative Dispute Resolution Service. Those rules of procedure shall be modified by this Section 12.8-2. The decision of the arbitrator shall be final, binding, unappealable, and unreviewable, shall be enforceable in accordance with the Federal Arbitration Act and the Wyoming Uniform Arbitration Act, and shall survive Practitioner's membership on the Medical Staff.

Arbitration shall be initiated by making a written demand for arbitration on the other party or parties. Such a demand shall be made not later than six months after the date of the claim, controversy, or dispute arises, or 30 days after completion of the appellate review procedure, whichever is later. Failure to make demand for arbitration within the required time shall bar all claims.

The arbitrator may not award punitive, consequential, nor indirect damages. The Practitioner, Medical Staff and Hospital, by instituting, participating in, or making any claim in the arbitration, shall be deemed to have waived the right to assert or obtain such damages and shall be deemed to have agreed to accept only those actual damages directly resulting from the claim asserted. The arbitrator will apply the substantive law of Wyoming and the United States.

The burden of proof shall be as set forth in Section 12.5-6.

Presentation of new or additional matters or evidence not raised or presented during the original hearing, in the Hearing Committee's report, or on appellate review, or not otherwise reflected in the record, shall be permitted only under unusual circumstances. The arbitrator, in his sole discretion, shall determine whether the presentation of such matters or evidence shall be permitted.

Until the rendering of the arbitration award, the parties to the arbitration shall pay their own costs and expenses, and share equally the costs and expenses of the arbitration proceedings. Following the arbitration award, the arbitrator shall award to the prevailing party, as determined by him, all of its costs and fees, including without limitation, pre-award fees of the arbitration, arbitrator's fees, travel expenses, hearing costs, out-of-pocket costs associated with the arbitration and reasonable attorney fees.

Except as needed for presentation in lieu of a live appearance, depositions will not be taken. Parties will be entitled to conduct document discovery by requesting production of documents. Responses or objections will be served 20 days after receipt of a request. The arbitrator will resolve any discovery disputes by such pre-hearing conferences as he deems necessary.

12.9 GENERAL PROVISIONS

12.9-1 SUMMARY SUSPENSION - EXPEDITED PROCEEDINGS

A Practitioner who is under a suspension, which is then in effect, may waive the minimum times provided by Sections 12.4-1(a) and 12.6-2 for notice of a hearing or appellate review, and the proceeding shall then be expedited to the extent feasible.

12.9-2 WAIVER BY FAILURE TO REQUEST A HEARING.

A Practitioner who fails to timely request a hearing or appellate review waives all rights to such proceeding and to all other rights under these Bylaws to which he might otherwise have been entitled. Such waiver, in connection with:

- (a) An adverse action by the Board shall constitute acceptance of that action which shall then become effective as the final decision of the Board.
- (b) An adverse recommendation by the Medical Executive Committee or the Hearing Committee shall constitute acceptance of that recommendation which shall then become and remain effective pending the final decision of the Board.

The Chief Executive Officer shall promptly send the Practitioner special notice informing him of each action taken after waiver and shall notify the Chief of Staff of each such action.

12.9-3 NUMBER OF REVIEWS

Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one hearing and appellate review with respect to an adverse action.

12.9-4 RELEASE

By requesting a hearing or appellate review, a Practitioner agrees to be bound by the provisions of this Chapter 12.

12.10 EXCEPTIONS TO HEARING RIGHTS

12.10-1 EXCLUSIVE CONTRACTS

The Board of Directors is ultimately responsible for entering into exclusive contracts with members of the Medical Staff and/or transferring exclusive contracts to another group or groups. A committee of the Board of Directors, the Joint Operations Board of Directors (“JOB”), which is composed of members of the Medical Staff, the Board of Directors, and administration, is responsible for making a recommendation to the Board of Directors on whether to enter into an exclusive contract and to whom the exclusive contract should be provided. In making this decision, the JOB should determine whether an exclusive contract is necessary to achieve the coordination and standardization of care which will support a more efficient and effective patient delivery system. The JOB will determine whether the exclusive contract will improve the quality of care and will ensure it incorporates appropriate quality assurance measures in the contract. Input from appropriate members of the Medical Staff, the Medical Executive Committee and Administration will be obtained by the JOB as appropriate.

12.10-2 IMPACT OF EXCLUSIVE CONTRACT ON MEDICAL STAFF MEMBERSHIP

A decision pursuant to Section 12.10-1 to enter into an exclusive contract or transfer an exclusive contract to another group or groups does not trigger any hearing rights pursuant to the Medical Staff Bylaws to those affected, shall not be considered an adverse action, or trigger a Data Bank report. These decisions are of general application intended to address an administrative or clinical service issue as a whole and are not directed at specific individuals.

12.10-3 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required when a member’s license or legal credential to practice has been revoked or suspended as set forth in Section 11.3-1(a). In other cases described in Sections 11.3-1 and 11.3-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority of the DEA and Wyoming Board of Pharmacy was unwarranted, but only whether the member may continue practice in the Hospital with those limitations imposed.

12.11 NATIONAL PRACTITIONER DATA BANK REPORTING

12.11-1 ADVERSE ACTIONS

The Hospital’s Authorized Representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the Board of Directors, provided, however, that summary suspensions based on professional competence of professional conduct that last more than 30 days may be reported in accordance with applicable Data

Bank statutes and regulations. The Hospital's Authorized Representative shall report any and all revisions of an adverse action in accordance with Data Bank statutes and regulations. Additionally, the Hospital's Authorized Representative shall report any and all surrender, restriction of, or failure to renew Privileges while an individual is under investigation, pursuant to Data Bank statutes and regulations. Data Bank statutes and regulations will apply to determine whether an individual is under "investigation" for purposes of Data Bank reports.

CHAPTER 13 CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS

13.1-1 PRACTITIONERS

By applying for or exercising Clinical Privileges within the Hospital, an applicant:

- (a) authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;
- (b) authorizes persons and organizations to provide information concerning such Practitioner to the Medical Staff;
- (c) agrees to be bound by the provisions of this Chapter and to waive all legal claims against any representative of the Medical Staff or the Hospital who in good faith acts in accordance with the provisions of this Chapter; and
- (d) acknowledges that the provisions of this Chapter are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of Clinical Privileges at this Hospital.

13.1-2 BOARD OF DIRECTORS

By approving these Medical Staff Bylaws and by granting Medical Staff membership and Clinical Privileges to individual Medical Staff members, the Board of Directors:

- (a) acknowledges that many of the functions of the Medical Staff described in these Bylaws are carried out at the request of and primarily for the benefit of the Hospital, in order that the Hospital may be licensed and accredited; and
- (b) agrees on behalf of the Hospital to indemnify and hold harmless the Medical Staff, individually and collectively, from loss, damage, or expenses incurred in connection with the performance of the following functions, as long as these functions are performed in good faith:
 - (1) the credentialing of applicants;
 - (2) the performance of the quality assessment, quality improvement and utilization review functions;
 - (3) the performance of the corrective action functions;
 - (4) the performance of any functions required or indicated by the impaired Medical Staff member policy;

- (5) any action undertaken within the scope of the member's duties as an officer of the Medical Staff, a Department Chair, a committee member, or any other elected or appointed office or position; or
 - (6) the performance of any other authorized action taken at the direction and on behalf of the Hospital.
- (c) The Board shall fulfill its indemnification obligation by maintaining adequate and appropriate insurance on behalf of the Medical Staff members against liability incurred or asserted against any Medical Staff member in his or her capacity as an officer of the Medical Staff, a department or division officer, a committee member, or any other elected or appointed office or position. The Board will annually report to the Executive Committee the type and amount of indemnity insurance carried and shall also report any amendments to the type and amount of insurance.

13.2 CONFIDENTIALITY OF INFORMATION

13.2-1 GENERAL

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees under Chapters 11 or 12 or ad hoc committees or by departments and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential. This shall apply to individual(s) involved in peer review when acting on behalf of the appropriate Peer Review Committee. Dissemination of such information and records shall only be made where expressly required by law; pursuant to officially adopted policies of the Medical Staff, or, where no officially adopted policy exists, only with the express approval of the Executive Committee or its designee. Any confidential information collected pursuant to these Bylaws shall be marked "Confidential."

13.2-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, divisions, or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital and the Medical Staff. If it is determined that such a breach has occurred, the Executive Committee may undertake such corrective action as it deems appropriate.

13.3 IMMUNITY FOR PROVIDING INFORMATION

Representatives of the Medical Staff or Hospital, and all third parties providing information to the Medical Staff or Hospital, shall not be liable in any judicial proceeding

for damages or other relief to an applicant or Medical Staff member by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an applicant to, or member of, the Medical Staff, or, who did, or does, exercise Clinical Privileges or provide services at this Hospital provided that such representative or third party acts in good faith and without malice.

13.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Chapter shall apply to all acts, communications, reports, recommendations 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) application for appointment, reappointment, or Clinical Privileges including Temporary Privileges;
- (b) corrective action;
- (c) hearings and appellate reviews;
- (d) utilization reviews;
- (e) other department, division, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- (f) National Practitioner Data Bank queries and reports, peer review organization reports, Wyoming State Board of Medicine reports, and similar reports.

13.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Chapter, subject to such requirements, including those of good faith, absence of malice, and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State of Wyoming. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Chapter.

13.6 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, indemnification, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

13.7 AUTHORITY TO ACT

Any member or members of the Medical Staff who act in the name of the Hospital or Medical Staff without proper authority shall be subject to such disciplinary action as the

Executive Committee may deem appropriate. Any member or members of the Hospital who act in the name of the Hospital or Medical Staff without proper authority shall be subject to such disciplinary action as the Board of Directors may deem appropriate.

13.8 ORGANIZED HEALTH CARE ARRANGEMENT

The Hospital and the members of the Medical Staff constitute an organized health care arrangement (“OHCA”) to allow the exchange of protected health information for treatment, payment and healthcare operations of the OHCA. The terms “organized health care arrangement” and “protected health information” shall have the meanings set forth in the Health Insurance Portability and Accountability Act (“HIPAA”). The OHCA participants provide services to mutual patients in a clinically integrated care setting and the sharing of such information benefits the common enterprise by allowing the participants to improve their joint operations and further quality patient care. The OHCA participants agree to abide by the terms of the joint *Notice of Privacy Practices* provided to patients of the Hospital. Each participant remains responsible for individual HIPAA compliance efforts. The OHCA does not mean that any participant is responsible for the violations of another participant.

CHAPTER 14 GENERAL PROVISIONS

14.1 RULES AND REGULATIONS

The Medical Staff shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its Rules and Regulations to comply with current Medical Staff practice. Recommended changes to the Rules and Regulations shall be submitted to the Executive Committee for review and evaluation prior to presentation for consideration by the Medical Staff as a whole. Adoption of, or changes in, the Rules and Regulations shall require a two-third majority vote of the Medical Staff members present and voting at a properly noticed meeting at which a quorum is present. Following the adoption of the Rules and Regulations or adoption of the changes therein, such Rules and Regulations shall become effective following approval of the Board of Directors, which approval shall not be withheld or delayed unreasonably. Applicants and members of the Medical Staff shall be governed by such Rules and Regulations as are properly initiated and adopted. When the Rules and Regulations are adopted by the Medical Staff and approved by the Board of Directors they shall be considered a part of these Bylaws. If there is a conflict between the Medical Staff Bylaws and the Rules and Regulations, the Medical Staff Bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations.

14.2 DUES OR ASSESSMENTS

The Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, subject to approval of a two-third majority vote of the Medical Staff members present and voting at a properly noticed meeting at which a quorum is present. The Executive Committee shall determine the manner of expenditure of annual dues or assessments. The Executive Committee shall have the authority to recommend an application or reappointment fee subject to the approval of a two-third majority vote of the Medical Staff members present and voting at a properly noticed meeting at which a quorum is present.

14.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both sexes wherever either term is used.

14.4 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service, first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable, is expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or officers or committees thereof, shall be addressed as follows:

Director of Medical Staff Services
Wyoming Medical Center
1233 East Second Street
Casper, WY 82601

Mailed notices to a member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

14.5 INTERNS AND RESIDENTS

Interns and residents are employees and students of the University of Wyoming Family Practice Residency Program. They are not entitled to medical staff membership or to any of the due process rights set forth in the Medical Staff Bylaws for members of the medical staff; provided, however, they are required to comply with all of the parameters and obligations of the Medical Staff Bylaws, Rules and Regulations and all applicable Departmental Policies and Protocols. Residents are supervised in accordance with the Graduate Education Program Supervision Policy.

14.6 ADOPTION AND AMENDMENT OF BYLAWS

These Bylaws shall be reviewed annually and may be amended in the following manner. Amendments shall be presented to the Executive Committee for approval by a two-third vote of all Executive Committee members eligible to vote. If approved by the Executive Committee, amendments shall be circulated to the Medical Staff for at least a thirty (30) day notification period. The amendment shall be presented for discussion at the next regularly scheduled Medical Staff meeting or, if the provisions in Section 9.3-2 are followed, at a special meeting of the general Medical Staff. Voting is by written ballot, which shall be distributed at the meeting and by mail. Ballots must be submitted either at the meeting or within 10 business days, and a two-third majority of ballots submitted is required for approval of the amendments.

If the Medical Staff wishes to propose to adopt a rule, regulation or policy or amendment to the Bylaws, a sponsoring member of the Active Medical Staff shall prepare a petition. The petition should contain the proposal to be discussed and consist of the exact language proposed or contested. The petition, if signed by not less than twenty-five percent (25%) of the Active Medical Staff, shall be submitted to the Medical Executive Committee. The Medical Executive Committee shall respond to the petition within 60 days. If the MEC rejects the proposal, the sponsor of the petition may present the issue for discussion at the next regularly scheduled Medical Staff meeting or, if the provisions in Section 9.3-2 are followed, at a special meeting of the general Medical Staff. Written ballots may then be circulated at the meeting and for ten (10) business days thereafter. A two-thirds majority of the votes cast in favor of the amendment or its modification or repeal is required to present the resolution to the Board.

Such amendments shall become effective when approved by the Board and such approval shall not be unreasonably delayed or withheld. The Bylaws, when adopted and approved, shall be equally binding on the Board of Directors and the Medical Staff. The Board of

Directors reserves the authority to take any direct action that is appropriate with respect to any individual appointed to the Medical Staff or given Clinical Privileges or the right to practice in the Hospital.

14.7 MANAGEMENT OF CONFLICT BETWEEN THE MEDICAL STAFF AND THE MEDICAL EXECUTIVE COMMITTEE

If a conflict exists between the Medical Staff and the MEC, upon a petition signed by twenty-five percent (25%) of the Active Medical Staff, the matter shall be submitted to the following conflict resolution process: The issue shall be discussed at a regularly scheduled Medical Staff meeting or, if the provisions in Section 9.3-2 are followed, at a special meeting of the Medical Staff. If the conflict is not resolved at the meeting, nominations will be solicited for three or more representatives of the members of the Active Medical Staff to participate in an ad hoc committee formed for purposes of resolving the conflict. If more than three names are submitted as representatives, the three names with the highest number of votes will be selected. Voting is by secret written ballot. The ballot will be distributed by the end of the next business day following the meeting and may be turned in ten days following the meeting. The Medical Executive Committee shall also select three representatives for the ad hoc conflict resolution. The Hospital CEO or his/her designee shall be an ex-official, non-voting member of the ad hoc conflict resolution committee. The members of the ad hoc conflict resolution committee shall work in good faith to resolve the differences between the parties in a manner consistent with protecting safety and quality. If necessary, the ad hoc conflict resolution committee will bring in a mediator, who will be paid by the Hospital.

14.8 HISTORY AND PHYSICAL EXAMINATION

- (a) The admission or registration history and physical examination must be an appropriate assessment performed by a Physician for all inpatients and for all outpatients. The Physician uses his/her clinical judgment based on his/her assessment of the patient's condition, and any co-morbidities, in relation to the reason the patient was admitted or registered, when deciding what depth of assessment needs to be performed. The assessment must be sufficient to justify the medical necessity of the treatment or service. In the case of an emergency the appropriate assessment must be made but need not be documented in the chart until a later time. For all inpatients, emergency department patients, and outpatients receiving anesthesia, including moderate sedation, any type of surgery, other procedure that place the patient at risk, or evaluation and management services, this assessment must include a chief complaint, history of the present illness, physical examination, family history, diagnosis and plan. The assessment may also include, as appropriate, current medications, medical allergies, past medical history, social history, and a review of systems. The history and physical for patients in the Clinical Decision Unit for observation status must meet applicable evaluation and management documentation requirements. For patients who, pursuant to a Hospital contract with a hospice provider, are receiving only inpatient hospice or respite care services, a properly completed hospice plan of care may serve as the assessment. The history and

physical must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but before surgery or a procedure requiring anesthesia services, including moderate sedation. The history and physical may be handwritten or transcribed, but always must be entered or scanned into the patient's electronic medical record within 24 hours of admission or registration or before surgery or a procedure requiring anesthesia, including moderate sedation, whichever comes first. Negative findings will be documented appropriately.

- (b) Updates. If a complete history has been recorded and a physical examination performed by a Physician with Clinical Privileges at Wyoming Medical Center within 30 days before the patient's admission or registration, a reasonably durable, legible copy of the report may be used in the patient's medical record in lieu of the admission or registration history and physical; provided, however, that an update on the patient's condition must be completed and documented in the patient's medical record within 24 hours of admission or registration. The history and physical must be updated, signed, and dated according to the provisions herein and the Medical Staff Policy. If the history and physical was performed more than 30 days before admission or registration, it must be redone. In all cases, if the patient is having surgery or other procedures that place the patient at risk and/or involves the use of sedation or anesthesia within the first 24 hours, there must be an update to the patient's condition before the start of the surgery/procedure. If the update has been dictated but, due to extenuating circumstances, is not transcribed at the time surgery or other procedures that place the patient at risk and/or involves the use of sedation or anesthesia, this requirement may be met by scanning into the patient's record, a handwritten history and physical prepared using the Hospital's designated form for such history and physicals.

Any such update must be completed and documented by a Physician who has Clinical Privileges to perform a history and physical for inpatients or registered outpatients. An update must document an examination for any changes in the patient's condition since the history and physical was performed that might be significant for the planned course of treatment. If, upon examination, the Physician finds no change in the patient's condition since the history and physical was completed, he may indicate in the patient's medical record that the history and physical was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the history and physical was completed. Any changes in the patient's condition must be documented in the update note.

- (c) Nurse practitioners who have been granted such Privileges may perform part or all of a patient's medical history and physical examination. Physician assistants who have been granted such Privileges may perform part or all of a patient's medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified Physician who is accountable for the patient's medical history and physical examination. For history and physicals

performed by nurse practitioners, the accountable Physician must sign and date the assessment and any update.

- (d) All patients scheduled for procedures to be performed under general, or major conductive regional anesthesia, or moderate or deep sedation, are required to have a pre-operative diagnosis recorded in the medical record.
- (e) The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending Practitioner's office record transferred to the Hospital admission. An interval admission note must be written, which included pertinent additions to the history and any subsequent changes in physical findings.
- (f) Except in emergencies, or any emergency surgery or procedure requiring moderate sedation or anesthesia, the patient's physical examination and medical history, any diagnostic tests, and the pre-operative diagnosis are completed and recorded in the medical record.
- (g) Inpatient History and Physical forms, approved by the Medical Staff, may be used instead of dictation or direct entry into the electronic medical record system.
- (h) The admitting or registering nursing historical assessment may be utilized as part of the Physician's admitting or registration history and physical examination only when that nursing assessment is reviewed by the Physician. The Physician must document his review and whether or not he agrees with the assessment.
- (i) All inpatient physical examinations must include examination of the heart, lungs, and abdomen.