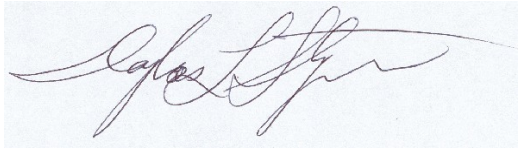
GULF COAST MEDICAL CENTER

MEDICAL STAFF BYLAWS

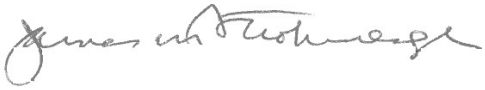
Appendix A:
FAIR HEARING PLAN

Appendix B:
RULES AND REGULATIONS

Last Review & Revision – August 2006



Chief of Medical Staff, 2007
Douglas Stringer, M.D.



Chairman of the Board of Trustees, 2007
James Strohmenger, M.D.

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ARTICLE I

Definitions

The following terms shall have the meanings set forth in this Article, unless the context clearly indicates otherwise. Note: Some of the terms defined in this Article I are not capitalized when used throughout these bylaws.

1. Administration - executive members of the Administration of the Hospital, including the Administrator.

2. Admitting Privileges - the prerogatives granted to certain members of the staff to admit patients to the Hospital.

3. Allied Health Professionals - Individuals other than physicians, dentists, or podiatrists who are sponsored by and/or supervised by practitioners, under contract, or employed by the Hospital (and require credentialing by the medical staff).

4. Approved Residency - those residencies approved by AOA and ABMS.

5. Board - the governing Board of Trustees of the Hospital.

6. Bylaws Committee - the standing committee of the staff that is constituted by and serves in the manner provided in Article XI, Section 4 of these Bylaws.

7. Administrator - the individual acting on behalf of the Board responsible for the overall management of the Hospital. The Administrator of the Hospital.

8. Clinical Privileges - the permission granted to a practitioner, an appointee of the Medical Staff, by the Hospital to render specific professional services.

9. Credentials Committee - the standing committee of the staff that is constituted by and serves in the manner provided in Article XI, Section 6 of these Bylaws.

10. Dentists - an individual who has received a Doctor of Dentistry degree and is currently licensed to practice dentistry in the state of Florida.

11. Employee - this definition applies to the activities in this hospital by Allied Health Practitioners. An employee must be guaranteed a periodic wage documented by a W-2 form (with federal income tax, social security and Medicare taxes withheld). The physician-employer may be required to provide evidence that Florida Unemployment Taxes have been paid by submitting the original 1160 form on request. The physician-employer must maintain direction and control of all activities of the Allied Health Practitioner employee including, but not limited to, when to do the work, what equipment or supplies to use, what work must be performed, and what order or sequence to follow. Even if no instructions are given, the physician-employer retains the right to control how the work results are achieved.

12. Executive Committee - the standing committee of the staff that is constituted by and serves in the manner provided in Article XI, Section 3 of these Bylaws.

13. Fair Hearing Plan - the Fair Hearing Plan attached to these Bylaws as Appendix A.

14. HCQIA - the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. lll0l et seq.

15. Hospital - Bay Hospital, Inc. d/b/a Gulf Coast Medical Center, 449 W. 23rd St., Panama City, Florida, which is a subsidiary of Columbia/HCA Healthcare Corporation, a proprietary corporation.

16. Invasive Procedure - A procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including but not limited to percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, implantations, and excluding venipuncture and intravenous therapy.

17. Nominating Committee - the standing committee of the staff that is constituted by and serves in the manner provided in Article XI, Section 5 of these Bylaws.

18. Performance Improvement- the terms quality assurance, continuous quality improvement, performance improvement, and quality improvement are meant to be synonymous and reflect the organization's goal to continuously improve quality.

19. Physician - an individual who has received a Doctor of Medicine or Doctor of Osteopathy Degree and is currently licensed to practice medicine or osteopathic medicine in the State of Florida.

20. Physician Assistant - an individual who is currently certified and licensed either as a "physician assistant" or as an "osteopathic physician assistant" in the state of Florida.

21. Podiatrist - an individual who has received a Doctor of Podiatry and is currently licensed to practice podiatric medicine in the state of Florida.

22. Practitioner - unless otherwise limited, any physician, dentist or podiatrist.

23. Psychologist - an individual who has received a Doctoral Degree in psychology and is currently licensed to practice psychology in the state of Florida.

24. Rules and Regulations - the rules and regulations of the staff attached to these Bylaws as Appendix.

25. Staff - The single organized medical staff of the Hospital which is comprised of physicians, dentists and podiatrists who have been extended the privilege of staff appointment as provided under these Bylaws. The staff is an integral part of the Hospital and is not a separate legal entity.

26. Staff Year - the year beginning January 1 and ending December 31 of each calendar year.

27. Telemedicine - The practice of medicine through the use of communication technologies to support clinical care.

ARTICLE II

Name, Purposes, Responsibilities

1. Name. The name of the Medical Staff shall be the "Medical Staff of Gulf Coast Medical Center."

2. Purposes. The purposes of the staff are:

   A. To provide patients with the quality of health care which is commensurate with acceptable standards and available community resources;

   B. To serve as a primary means for accountability to the Board concerning professional performance of practitioners authorized to practice at the Hospital and for performance improvement;

   C. To provide an educational setting that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skill;

   D. To adopt rules and regulations for the proper functioning of the staff;

   E. To provide a means for discussing issues concerning the staff with the Board and the Administration; and

   F. To assist the Board by serving as, or providing members who will constitute and serve as, professional review bodies in conducting professional review activities.

3. Responsibilities. The staff shall account and report to the Board and Administration with appropriate recommendations regarding performance improvement activities in the Hospital by means of:

   A. Mechanisms for appointment and reappointment of competent, qualified practitioners and the delineation of clinical privileges;

   B. Continuing medical education programs;

   C. Utilization review programs;

   D. Evaluation of patient care;

   E. Procedures for peer review and corrective action with respect to practitioners and allied health professionals when warranted;

   F. Developing and monitoring compliance with these Bylaws and the Rules and Regulations; and

   G. Identify community health needs in establishing appropriate institutional goals.

4. Reporting. The Staff shall take all actions necessary to assist the Board and the Hospital in complying with the reporting requirements of law, including HCQIA, governing professional review actions and/or disciplinary actions with respect to practitioners and allied health professionals in connection with the Hospital.

5. Obtaining Reported Information. The staff shall request from the Department of Health and Human Services, or from the appropriate agency designated by the Secretary of Health and Human Services, information reported under the Health Care Quality Improvement Act of 1986 concerning any practitioner or allied health professional:

   A. At the time he applies for staff membership or clinical privileges at the Hospital, and

   B. At least once every two years for each such practitioner or allied health professional.

ARTICLE III

Medical Staff Appointment

1. Nature of Appointment. Staff appointment is a privilege extended by the Hospital, and not a right of any practitioner or other person. Staff appointment and the exercise for privileges in connection therewith shall be extended only to practitioners who continuously meet the requirements of these Bylaws and satisfy any other applicable standards issued by the Board. Admitting and clinical privileges shall be limited to staff appointees; such privileges will be granted to practitioners by the Board.

   For purposes of these Bylaws "membership in" is used synonymously with "appointment to" the staff.

2. Qualifications. Only practitioners duly licensed to practice in the State of Florida shall be eligible for appointment to the staff. The eligibility of each practitioner applying for staff appointment shall be determined on the basis of his relevant training and experience, background, and the practitioner's affirmation that he/she has the mental and physical ability to perform privileges requested, all with respect to whether patients treated by him will receive care of the generally recognized professional level established by the Hospital and on the basis of documented references, the practitioner's reputation, his strict adherence to the ethics of his profession, his ability to work cooperatively with others, his willingness to participate in the discharge of staff responsibilities, and other such elements as the Board may determine. Applicants who have felony convictions will be ineligible.

   Applicants must provide:

   A. Proof of U.S. citizenship with a state-certified birth certificate, naturalization papers or U.S. passport; (Those with current clinical privileges must provide this proof at their next biannual appointment application. This section in parenthesis will expire in December 2006 and may be deleted at that time.); or

   B. Present a current valid INS Work Permit. Failure to maintain a current valid Work Permit will result in immediate revocation of clinical privileges.

   Applicants will be considered only if they are board certified or active candidates for board certification in their specialty by an ABMS-recognized Board or an AOA-recognized Board in which they are seeking privileges. Exception: Emergency Room physicians may be from any specialty if properly qualified by the credentials and emergency room committees. Those applicants can only be accepted if they sign an agreement to voluntarily relinquish their privileges if they do not achieve board certification within seven years of the first date of eligibility or the time frame allowed by their specialty board, whichever is shorter. Failure to attain board certification or remain an active candidate for board certification while on the Medical Staff will constitute grounds for termination of appointment. Additionally, applicants must have completed an ACGME accredited program which was not on probation during the applicant's training period. The applicant must have remained in the same residency training program for a minimum of two years. Current members of the staff (as of 11/97) will not be required to meet these criteria as long as they remain members in good standing.

   An applicant who is a podiatrist must be a graduate of a college of podiatric medicine, accredited by the council on podiatric education of the American Podiatric Medical Association and either must be certified by the American Board of Podiatric Surgery or must have satisfactorily completed a two-year surgical residency program in podiatry approved by the Council on Podiatric Education of the American Podiatric Medical Association, as verified by the director of the program.

   No person shall be automatically entitled to staff appointment or to the exercise of clinical privileges merely because he has a license to practice, is a member of any professional organization, is certified by any board, or has staff appointment or clinical privileges in this or any other health care facility. All physician applicants (M.D.'s and D.O.'s) shall have completed an approved residency. The residency shall determine the department(s) through which privileges are granted. The residency shall also be the basis for the privileges granted. The burden shall be on the applicant to establish his qualifications. Acceptance of staff membership or exercise of clinical privileges shall constitute an agreement to strictly abide by these Bylaws, the Rules and Regulations and, as appropriate, the principles of medical ethics of the American Medical Association and the American Osteopathic Association, the code of ethics of the American Dental Association or other appropriate ethical standards governing the practitioner's practice. No person shall be appointed to the staff or granted

clinical privileges if the Hospital is unable to provide adequate facilities in support of services for the applicant and his patients. Staff appointment shall not be denied on the basis of age, sex, race, creed, color or national origin.

3. Basic Responsibilities. Except as otherwise provided in these Bylaws, each staff member shall:

   A. Provide continuous care to his patients at the generally recognized professional level of quality and efficiency;

   B. Abide by these Bylaws and the Rules and Regulations;

   C. Discharge such staff, department, committee and Hospital functions for which he is responsible; and

   D. Prepare and complete in a timely manner the medical and other required records for patients as provided in the Rules and Regulations.

4. Terms. Initial appointments and any reappointments will be made by the Board upon its consideration of the recommendation of the staff. Reappointments shall be for a maximum period of two years upon reapplication.

5. Practitioner Employees. Any practitioner employed by the Hospital who wishes to be a member of the staff and/or exercise clinical privileges must apply for and maintain such staff membership and/or clinical privileges in the same manner as other practitioners. Termination of such employment shall not automatically result in termination of staff appointment or of clinical privileges, except as specifically provided in these Bylaws. Contracts between the Hospital and any practitioner concerning the rendition of services shall be governed by Article VI, Part C, Section 4.

6. Leave of Absence. A staff member may obtain a voluntary leave of absence for a period of not less than 60 days nor to exceed one year by submitting written notice to the chairman of the department to which he is assigned and to the Administrator or designee. During such leave, the member's privileges and prerogatives shall be suspended. At least thirty days prior to termination of leave, the staff member may request reinstatement by written request to the Administrator or designee, which shall include a summary of his activities during the leave. The Administrator or designee shall forward the request to the Executive Committee, which shall then make a recommendation to the Board as to reinstatement. Failure to request reinstatement shall result in voluntary resignation of staff appointment at the leave expiration date. In the event of a medical leave of absence, the practitioner will reaffirm that he/she has the mental and physical ability to perform the privileges requested.

ARTICLE IV

Categories of the Staff

1. Categories. The staff shall include Active, Associate, Reserve, Consulting, Courtesy and Honorary categories. All staff members who may admit patients must maintain their primary office in Bay County and reside within Bay County or within a radius of 30 miles of Gulf Coast Medical Center in order to provide continuous care to his patients.

2. Active Staff.

   A. Qualifications. The active staff shall consist of practitioners:

      (1) Who regularly admit patients to, or are otherwise regularly involved in the care of patients in the Hospital; and

      (2) Who assume all of the functions and responsibilities of membership on the active staff including, where appropriate, emergency service care and consultation assignments.

   B. Prerogatives. Subject to availability of beds, each member of the Active staff may:

      (3) Admit patients without limitation, except as otherwise provided in these Bylaws or the Rules and Regulations;

      (4) Exercise such clinical privileges as are granted to him;

      (5) Vote on all matters presented at staff meetings and of the departments and committees of which he is an appointee; and

      (6) Hold a staff, department or committee office.

   C. Responsibilities. Each member of the active staff shall:

      (1) Discharge the responsibilities of staff members as required in these Bylaws;

      (2) Provide continuous care and supervision of his patients in the Hospital or arrange a suitable alternative;

      (3) Actively participate in performance improvement and peer review activities required of the staff;

      (4) Attend staff and department meetings;

      (5) Participate in Emergency Room call for their respective department; and

      (6) Perform such further duties as may be required of him under these Bylaws or the Rules and Regulations.

3. Associate Staff.

   A. Qualifications.

      (1) The Associate Staff shall consist of all initial appointees to the staff.

      (2) Associate Staff members shall be granted clinical privileges on a provisional basis as provided in this section and in Article VII, Section 4.

      (3) Associate Staff shall be eligible for advancement to other membership, categories (active, reserve, consulting, or courtesy), but their status shall not be as full members of the staff until such advancement occurs.

(4) Each Associate Staff member shall be assigned to a clinical department, and his performance shall be observed and evaluated by the department chairman or his designee to determine his eligibility for advancement to another category of the staff.

(5) Appointments to the Associate Staff, and provisional privileges granted to Associate Staff members, shall be for a period of no less than one year. This period may be extended for an additional six months on the recommendation of the chairman of the department to which he is assigned, if there has not been adequate opportunity to observe his professional performance due to lack of utilization of the Hospital for care or a sufficient number of patients. Any decision to extend the period for appointment to the Associate Staff or provisional privileges shall not be deemed to be adverse action involving the Associate Staff member and shall not entitle him to the procedures reported by the Fair Hearing Plan.

(6) After completion of the period for which Associate Staff membership and provisional privileges have been granted, the appointees shall be advanced to other categories as requested, in which case his clinical privileges shall no longer be provisional in nature, or his appointment and privileges shall be terminated. The chairman of the department to which he is assigned shall submit a report and recommendation concerning such appointee to the Credentials Committee prior to the end of the extended period. The report and recommendation shall be considered at the next meeting of the Credentials Committee, which shall make a recommendation to the Executive Committee concerning the termination of Associate Staff membership and privileges or advancement in staff category. The Executive Committee shall consider the recommendation and shall thereafter make its recommendation concerning such matters to the Board, which shall promptly review the Executive Committee recommendation and make its decision concerning such matters.

B. Prerogatives. Each member of the Associate Staff:

(1) May admit patients to the Hospital under the same conditions corresponding to the category to which he/she is applying and may exercise such clinical privileges as are granted to him; and

(2) May not vote at staff or department meetings or hold office.

C. Responsibilities.

(1) Associate Staff members shall discharge the same responsibilities as those required, of the staff category to which he/she is applying, including participation in Emergency Room call for their respective department, if they expect to become members of the Active Staff upon completion of the Associate Staff, with the exception of the prerogatives stated above.

(2) Otherwise, they shall discharge the basic responsibilities of staff members as required in these Bylaws and perform such other duties as may be required under these Bylaws or the Rules and Regulations. Failure to fulfill those responsibilities shall be grounds for termination of clinical privileges or denial of reappointment.

4. Consulting Staff.

A. Qualifications. The Consulting Staff shall consist of physicians, dentists and podiatrists whose primary practice is located in Bay County within reasonable community distance to the hospital sufficient to provide continuing care to their patients and respond to emergency situations. They are appointed for the specific purpose of providing consultation at the request of an active or courtesy staff member in the diagnosis and treatment of patients in clinical specialties not provided by current active or courtesy staff members. If a physician, dentist, or podiatrist is appointed to the medical staff in the same specialty as provided by an active staff member, the consulting staff member must immediately voluntarily resign his or her membership and privileges or advance to active or courtesy membership status.

B. Prerogatives.

(1) Appointment to the Consulting Staff does not entitle the appointee to admit patients, to perform or assist in procedure, to vote or to hold staff offices, or to serve on medical staff committees.

(2) They may, but are not required, to attend department or medical staff meetings.

C. Obligations. Consulting staff members will be under the supervision of the Chief of the service to which they are assigned, who may limit their activities.

5. Courtesy Staff.

A. Qualifications. The Courtesy Staff shall consist of Bay County practitioners qualified for staff appointment who do not desire appointment to the Active Staff because they will admit or attend no more than 5 patients per month, including outpatient procedures, admissions and consultations, and excluding admissions occurring during Emergency Room call for unassigned patients.

B. Prerogatives.

(1) Appointment to the Courtesy Staff neither entitles the appointee to serve on medical staff committees, nor to vote, nor to hold office.

(2) They are encouraged to attend staff and department meetings.

C. Obligations.

(1) Courtesy Staff members will be obliged to participate in emergency room call at a frequency equal to one half of the call frequency of an Active Staff member in that respective department.

(2) An appointee to the Courtesy Staff shall be required to serve an initial provisional period as required for appointment to the Active Staff unless the appointee has previously served a provisional period in another staff category without a break in staff membership.

6. Reserve Staff.

A. Qualifications.

(1) The Reserve Staff shall consist of practitioners qualified by training and specialty, and certified by the usual credentialing process as stated in these Bylaws.

(2) Reserve Staff status is available for practitioners who wish to provide coverage for other practitioners on a temporary basis.

(3) In addition, Reserve status is available for those physicians who, by virtue of their special training and expertise, are invited to participate on a case-by-case basis, when options such as transferring the patient or delaying the management or treatment is not appropriate due to associated risk.

B. Prerogatives.

(1) No member of the Reserve Staff shall exercise any privileges until activated by an Active Staff member.

(2) Privileges are activated by the requesting Active Staff member requesting coverage, and similarly terminated by notifying the Administrator or designee.

(3) A Physician may be activated on the Reserve Staff for up to a total of 90 days in a period of one calendar year. Any special circumstances may be addressed by the Medical Executive Committee.

C. Responsibilities. Each member of the Reserve Staff, when activated, shall discharge the basic responsibilities of Active staff members as required in these Bylaws and perform such other duties as may be required under these Bylaws or the Rules and Regulations.

7. Emergency Room Physicians.

A. Qualifications. The emergency room staff will be physicians who serve in the Emergency Room.

B. Prerogatives. They will meet all the requirements of other members of the staff, but will not admit patients, and will not be required to maintain a place of practice in Bay County.

C. Obligations. They will be allowed to fulfill the requirements of attendance at 50% of their Department meetings by attending at least 50% of either the Department of Medicine or Emergency Center Committee meetings, or 50% of a combination of the two. They must, however, attend at least 50% of the Quarterly Staff meetings. They are encouraged to attend as many of the meetings as possible.

8. Telemedicine Staff.

A. Qualifications.

(1) Active Staff member(s) must sponsor these individuals, be of the same specialty as the telemedicine physician(s), and agree to be responsible for their actions.

(2) Telemedicine physicians serve as consultants, only, are not part of the consulting staff, and they cannot prescribe, treat or admit. Medical Staff members are ultimately responsible for the care and treatment of their patients.

B. Prerogatives.

(3) Applicants may not seek medical staff membership.

(4) They do not have to sit for the initial application interview.

(5) They do not have to meet the geographic requirement for geographic primary residence.

(6) They are ineligible to vote, serve on committees, or hold office.

(7) They have no meeting requirements.

C. Obligations. Applicants must apply for privileges and be processed in the same manner as other medical staff applicants pursuant to Article VI of the Medical Staff Bylaws subject to the exceptions noted above.

The Executive Committee will recommend privileges of telemedicine specialties and specialists on a case-by-case basis. The scope of responsibilities of approved telemedicine specialties will be noted in the Rules and Regulations, and may be amended in accordance with these Bylaws after appropriate Department approval.

9. Honorary Staff. The Honorary Staff shall consist of physicians who are not active in the Hospital and who are in emeritus positions. They may be:

A. Physicians who have retired from active hospital service; and/or

B. Physicians of outstanding reputation.

The Honorary Staff shall be appointed by the Board of Trustees upon recommendation of the Active Staff, and shall have no assigned duties or responsibilities.

10. The prerogatives of staff members in these Bylaws are general in nature and may be limited or restricted by special conditions attached to a practitioner's appointment or reappointment, by State law or regulations, other provisions of these Bylaws, the Rules and Regulations or other policies commitments, contracts or agreements of the Hospital as the same presently exists or as the same subsequently may be amended.

11. Authority of Board. Staff appointments and clinical privileges shall be denied, granted, modified, suspended, curtailed or revoked only by the Board, except as specifically and expressly provided in these Bylaws.

ARTICLE V

Allied Health Professionals

1. Eligibility. Qualified Allied Health Professionals who comply with applicable Florida law and satisfy the qualifications and requirements of these Bylaws and any applicable policies established by the Board under the employ or supervision of staff physicians may be eligible to provide specified services in the Hospital. Allied Health professionals may not be members of the staff, but advanced registered nurse practitioners, psychologists, physician assistants, physical therapists, speech therapists, nurse anesthetists, orthopedic brace specialists, mental health case workers, dietitians, radiation physicists, including but not limited to the above, may in certain cases, be extended clinical privileges as provided in these Bylaws, the applicable policies of the Board and any other matters that together constitute the standards and procedures of the Board. In any case of applications for, request for renewal of, and other actions with respect to such clinical privileges, the applicable standards and procedures of the Board shall be controlling, notwithstanding any contrary provision herein.

2. Physician Assistants and Advanced Registered Nurse Practitioners, Nurse Anesthetists, and Midwives. The physician is responsible and accountable for the care of his patients. To maintain this unbroken chain of responsibility, Physician Assistants, Advanced Registered Nurse Practitioners, Nurse Anesthetists, and Nurse Midwives delivering patient care in this facility must be employees, of a physician member of the active, courtesy or emergency physician categories of the medical staff. In this manner, there is no question that quality issues are ultimately the physician-employer responsibility, and he is directly responsible for the quality performance of his employees. Termination of the employee-employer relationship terminates the Allied Health Professional's privileges at the Hospital. It is the intent of these Bylaws to allow these individuals to be "physician helpers," not "physician substitutes." These individuals cannot admit patients. They cannot screen patients in the emergency room unless under the employ of the ER physician category of the medical staff. They cannot answer consults for their physician-employers. Their physician-employer is responsible for their hospital activities including, but not limited to, quality of care and behavior. Their activities may be further defined and limited in the Rules and Regulations portion of these Bylaws.

3. Qualifications. Allied health professionals shall document their qualifications, status, clinical competence, relevant experience, training, and the allied health professional's affirmation that he/she has the mental and physical ability to perform privileges requested, although an Active Courtesy or Emergency Staff member must be ultimately responsible for patient care. They may participate directly in patient care within the scope authorized by law the Hospital, and these Bylaws, Rules and Regulations. Allied health professionals must, on the basis of documented references, adhere to the ethics of their respective professions and to work cooperatively with others; must be individually assigned to an appropriate clinical department; and shall carry out their activities subject to the policies, procedures, rules and regulations of the Hospital and these Bylaws. Applicants who have felony convictions will be ineligible for credentialing.

   Applicants must provide:

   A. Proof of U.S. citizenship with a state-certified birth certificate, naturalization papers, or U.S. passport; (Those with current clinical privileges must provide this proof at their next biannual appointment application. This section in parenthesis will expire in December 2006 and may be deleted at that time.); or

   B. Present a current valid INS Work Permit. Failure to maintain a current valid Work Permit will result in immediate revocation of clinical privileges.

4. Procedure for Specification. An allied health professional shall submit an application for specified services on a form provided by the Administrator or designee. Each applicant shall be evaluated by the Credentials Committee, which shall recommend to the Executive Committee the scope of services which the applicant may be permitted to provide. If recommended and approved, the Executive Committee shall furnish a report and recommendation to the Board. If approved by the Board, the allied health professional will be assigned to the department appropriate to his training. Any decision as to the scope of activities of an allied health professional who is employed by an Active, Courtesy or Emergency Staff member or who is employed by, or under contract with the hospital (i.e. Perfusionist, Lithotripsy Technician/Nurses, Neurophysiologist, Speech Therapist, etc.) shall be valid only as long as

the allied health professional remains an employee of the Active, Courtesy, or Emergency Staff member, or an employee of, or under contract with, the Hospital.

5. Prerogatives. An allied health professional may:

   A. Provide specified patient care services solely under the supervision or direction of an Active, Courtesy, or Emergency Staff physician, as authorized by law and by these Bylaws;

   B. Write orders only to the extent permitted by law and granted by the Medical Staff and Board of Trustees, and in any event not beyond the scope of his license or certificate;

   C. Serve on committees;

   D. Attend department meetings when invited; and

   E. Be accorded disparate treatment based on qualifications, abilities and competence, subject to requirements of the law.

6. Responsibilities. Each allied health professional shall:

   A. Retain appropriate responsibility within his area of professional competence for the care and supervision of each patient in the Hospital for whom he is providing services;

   B. Participate as appropriate in performance improvement activities required of the staff;

   C. Attend all meetings of departments or committees as may be required; and

8. Evaluation. The respective departments shall examine, pass upon, limit and delineate the scope of activities within the Hospital, of allied health professionals who are duly licensed or certified and who provide services under the supervision or direction of a practitioner, subject to the approval of the Credentials Committee, the Executive Committee and the Board.

9. Approval. No allied health professional shall provide patient services in the Hospital until he has been reviewed by the Credentials Committee, recommended by the Executive Committee, and approved by the Board.

10. Bi-Annual Review. Every other year, at a time specified by the officer of the staff, each allied health professional shall submit a renewal application for specified services on a form provided by the Administrator and approved by the Medical Executive Committee and Board of Trustees. The procedure for bi-annual review shall be the same as the procedure for review of the initial application. The review shall also include the allied health professionals activities in the Hospital, performance, compliance with these Bylaws and the Rules and Regulations, ethics and conduct, relations with staff members and the Administration, clinical and/or technical skills, as indicated in part by the results of performance improvement activities, and such other information as may be appropriate.

11. Supervision. All activities of allied health professionals who provide care shall be under the supervision of, their sponsoring staff member(s) or under hospital contract, but such supervision shall not require the physical presence of the sponsoring staff member unless otherwise required by law. If any other hospital employee questions the authority or instructions of an allied health professional either to act or to issue instructions outside of the presence of the supervising staff member, the Hospital employee may delay acting until the supervising practitioner has validated the order or instructions of the allied health professional.

12. Indemnity. The practitioner, under whose supervision or direction an allied health professional provides patient care, or if under contract, the entity under contract with the hospital, shall indemnify the Hospital and hold the Hospital harmless from and against all currently existing or subsequently arising actions, causes of action, claims, damages, costs and expenses, including reasonable attorney's fees, resulting from, caused by, or arising from any act or omission of such allied health professional, including, without limitation, the negligence of such allied health professional or the failure of such allied health professional to satisfy the standards of proper care of patients.

ARTICLE VI

Appointment and Reappointment

1. Appointments.

   A. Application.

      (1) Contents. Individuals requesting appointment to the medical staff and/or clinical privileges shall be provided a preappointment application. Completed applications will be reviewed by the Credentials Committee. Only those individuals who meet qualifications as outlined in the Bylaws will be provided an application. Each application of a practitioner for staff appointment and/or clinical privileges shall be in writing, submitted on the prescribed form approved by the Board and signed by the applicant. A complete application shall include, without limitation:

         (a) A statement that the applicant has received and read the current staff Bylaws, Rules and Regulations, and Fair Hearing Plan and the current Hospital Bylaws and Policies (including, without limitation, the Board's policies with respect to staff membership, clinical privileges and applications therefore) and that he agrees to be bound by the same as they then exist or as they, from time to time, may be amended or supplemented if appointment or clinical privileges are granted and in all matters relating to whether membership or clinical privileges are granted;

         (b) Detailed information concerning the applicant's qualifications, including a copy of the applicant's medical school diploma and any specialty board certification;

         (c) Specific request stating the staff category and clinical privileges requested;

         (d) The names of at least three practitioners who will provide references as to his education, experience, clinical ability, ethical character and ability to work with others, and at least one of whom has worked with and personally observed the current professional performance of the applicant;

         (e) Information as to whether the applicant's membership or appointment or clinical privileges has ever been voluntarily or involuntarily terminated, revoked, suspended, reduced or not renewed in any other hospital or health care facility, and whether any membership or fellowship in any local, state or national professional organizations, specialty board certifications, license to practice any profession in any jurisdiction, or bureau of narcotics and dangerous drugs number has been suspended, revoked or denied; whether a challenge to any such licensure, membership, certification or registration is pending; whether any such licensure, membership, certification or registration has been voluntarily relinquished; and the particulars of any such matters shall be given;

         (f) Current information as to the applicant's professional liability insurance coverage;

         (g) Information as to all malpractice cases, actions or proceedings against him, either pending, settled, filed or threatened;

         (h) Information as to current ability to perform the privileges requested; and

         (i) Such other information as may be required in order to evaluate the applicant.

      (2) Certain Statements. The application shall include:

         a. A statement that the applicant understands and agrees to abide by the provisions of these Bylaws, including specifically those relating to privileges and immunities;

         b. A pledge by the applicant that includes an agreement to provide continuous care to patients;

         c. A statement releasing from any and all liability those persons to whom such privileges and immunities provisions of these Bylaws are intended to benefit;

d. A statement that the applicant agrees that when an adverse ruling is made concerning his appointment, staff status or clinical privileges, he will exhaust all remedies afforded by these Bylaws before resorting to formal legal action or commencing legal proceedings;

e. A statement as to his current ability to perform the privileges requested;

f. A statement that the applicant will, if his application is approved, report final judgments or settlements involving professional liability claims or proceedings to the Hospital within 5 business days after entered or made; and

g. A statement that the applicant will, if his application is approved, notify the Hospital within 5 business days of his receipt of a notice of intent to sanction from any peer review or professional review organization or any notice of intent to sanction or to revoke, suspend or modify his license from any state licensing or regulatory authority.

B. Other Requirements.

(1) Applicants will be required to sign a statement authorizing each institution at which they have enjoyed membership or privileges to provide copies of their credentialing files to the hospital. This letter would indemnify the cooperating institutions for any liability or damages related to sharing the credentialing data.

(2) Applicants will be required to provide copies of approved privileges from their most recent affiliated institution and residency training site.

(3) Applicants less than 5 years out of their training must submit names of 3 professional references in addition to internship, residency and fellowship training directors, who are personally acquainted with the applicant's professional and clinical performance and who the applicant considers as peers from within their same specialty. Applicants more than 5 years out of their training will also require 3 professional references as above but only verification of successful completion of internship/residency/fellowship will be required.

(4) Applicants must provide:

(a) Proof of U.S. citizenship with a state-certified birth certificate, naturalization papers, or U.S. passport; (Those currently on the medical staff must provide this proof at their next biannual appointment application. This section in parenthesis will expire in December 2006 and may be deleted at that time.); or

(b) Present a current valid INS Work Permit. Failure to maintain a current valid Work Permit will result in immediate revocation of membership and clinical privileges.

(5) Applicants who have not practiced in his/her specialty for the year preceding the application will be required to produce a statement providing a detailed explanation of their interim activity.

(6) Applicants will be required to provide their interventional procedure log from their residency program, and/or the number and types of surgical procedures performed/ medical cases managed as primary physician as signed by their Residency Director or Chairman of Department.

(7) Applicants are required to become board certified within 7 years of first date of eligibility and must be board certified in the specialty in which they are seeking privileges by an ABMS recognized Board with the only exception being an individual who recently completed training. Applicants can only be accepted if they sign an agreement to voluntarily relinquish their privileges if they do not achieve board certification within the time frame allowed by their specialty board. Current members of the staff (as of 11/97) will not be required to meet these criteria as long as they remain members in good standing.

(8) Applicants will be required to submit a statement from their physician advising whether the applicant has any medical problems that may interfere with the applicant's ability to practice medicine.

(9) If requested, applicants will be required to successfully complete an interview.

C. Burden on Applicants. The applicant shall have the burden of producing a fully complete application and such other information as may be reasonably requested for a proper evaluation of his experience, background, training, demonstrated ability, previous performance, current competence, physical and mental condition as it relates to ability to perform the privileges requested and of resolving any doubts about such matters.

D. Verification. Upon receipt of a completed application, the Administrator or designee shall arrange to verify the references, licensure and other qualification evidence submitted. Such verification shall include the obtaining of information reported pursuant to HCQIA. The Administrator or designee shall consult primary sources of information about the practitioner's credentials, where feasible. The Administrator or designee shall promptly notify the applicant of any problems in obtaining required information. It shall be the responsibility of the applicant to see that a report from the director of his training program and letters from his personal references are submitted directly to the Administrator or designee by such persons. After verification is accomplished and the application is fully complete, the Administrator or designee shall transmit a copy of the application and supporting materials to the Chairman of each department in which the applicant seeks privileges and request documented opinions and recommendations as to staff appointment or clinical privileges. The department Chairman or his designee shall conduct a personal interview of the applicant and may request additional information from the applicant, if he deems it necessary, in which event the applicant shall promptly furnish the requested information. Thereafter, the department Chairman shall prepare a written report and recommendations as to staff appointment and, if appointment is recommended, staff category and department, clinical privileges to be granted and any special conditions to the appointment. The reason for an adverse recommendation shall be stated, and the report shall then be transmitted to the Credentials Committee.

E. Credentials Committee Action. The Credentials Committee shall review the application, supporting materials, the report of department Chairman and such other available information as may be relevant to the applicant's qualifications. Within 90 days of receiving a completed application, the Committee shall transmit a written report and recommendation to the Executive Committee as to staff appointment and, if appointment is recommended, as to staff category and department, clinical privileges to be granted and any special conditions to the appointment. The reason for each adverse recommendation shall be stated.

F. Executive Committee and Board Action. At its next regular meeting, after receiving the Credentials Committee report, the Executive Committee shall consider the report and such other available information as may be relevant to the applicant's qualifications. The Executive Committee may request additional information from the applicant if such information may be helpful and in its evaluation of the application, and the applicant shall promptly furnish the requested information. The Executive Committee shall then prepare a written report and recommendation to the Board as to staff appointment and, if appointment is recommended, as to staff category and department, clinical privileges to be granted and any special conditions to the appointment. The reasons for each adverse recommendation shall be stated. The Committee may defer action where the deferral is not solely for the purpose of causing delay. When the recommendation is favorable, the Administrator or designee shall forward it promptly to the Board for action at its next regular meeting. If the recommendation of the Executive Committee is adverse, the Administrator or designee shall promptly notify the applicant. Such notice shall contain the information prescribed in the Fair Hearing Plan. In such case, the applicant shall be entitled to the procedural rights provided in the Fair Hearing Plan, and the recommendation need not be transmitted to the Board until after the applicant has exercised or waived such rights.

G. Subsequent Consideration. If after the procedural rights provided in the Fair Hearing Plan are exercised, the Executive Committee makes a favorable recommendation, it shall be processed as in the case of any other favorable recommendation. If, however, the recommendation remains adverse, the Administrator or designee shall promptly notify the applicant. Also, in such case, the Administrator or designee shall notify the Board, but the Board shall take no action until the applicant has exercised or waived his right to appellate review as provided in the Fair Hearing Plan. After all the applicant's procedural rights have been exercised or waived, the Board shall act on the application. The Board may approve or deny the applicant and may accept or reject the recommendation of the Executive Committee. A decision of the Board shall be final, and notice of

its decision shall be transmitted by the Administrator or designee to the Executive Committee and the Chairman of the department for which privileges are requested. Also, the Administrator or designee shall promptly notify the applicant, and if the decision is a denial, the Administrator or designee shall notify the applicant's licensing board of the denial. If the applicant then so requests in writing, the Board shall furnish the applicant with a writing that sets forth the reasons for the denial.

H. Reapplication. An applicant who has received an adverse decision regarding appointment and/or clinical privileges shall not again be considered for at least 2 years after final notice of the decision is sent. Any such application shall be processed as an initial application.

I. Provisional Privileges. All privileges granted shall initially be provisional in nature. Each practitioner granted clinical privileges shall be observed and evaluated by the department chairman in the manner provided in Article IV, Section 3, a, and Article VII, Section 4. If a medical staff member initially is approved for a category that must meet the geographic primary residence requirement, he must meet that residence requirement and be in practice within 90 days of his approval by the Board or be re-evaluated by the Executive Committee.

2. Reappointments.

A. Information. Two months prior to the applicant's birth month, the Administrator or designee shall ask each staff member or other individual exercising clinical privileges to furnish specific information in writing as to any changes he wishes in his staff appointment or clinical privileges. The information shall be furnished by the first day of the applicant's birth month to the Administrator or designee in a format approved by the Medical Executive Committee and the Board of Trustees. Failure to comply within thirty days of the first day of the applicant's birth month may represent grounds for non-reappointment and the relinquishment of privileges. Such information shall include matters concerning:

(1) Continuing training, experience and current competence qualifying the staff appointee for the privileges;

(2) Professional competence, clinical judgment and professional performance in the treatment of patients;

(3) Ethics and conduct;

(4) Attendance at staff meetings and participation in staff affairs;

(5) Compliance with these Bylaws and the Rules and Regulations;

(6) Use of Hospital facilities;

(7) Relations with other staff members and attitudes towards patients, the Hospital and the public;

(8) Continued ability to perform the privileges requested;

(9) Current licensure;

(10) Clinical and/or technical skills, as indicated in part by the results of performance improvement activities;

(11) Previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration;

(12) Voluntary or involuntary termination of medical staff membership or limitation, reduction or loss of clinical privileges at another hospital;

(13) Activities of any professional or peer review organization or sanctions imposed by any such organization or any licensing board or regulatory authority;

(14) Any pending or threatened to actions or legal proceedings involving professional liability claims;

(15) Proof of compliance with Florida Statute CME requirements must be submitted to the Credentials Committee coincident with, or prior to, state established deadlines. Failure to document shall subject the applicant to adverse recommendation for reappointment;

(16) Two peer references; and

(17) Such other information about the appointee's professional qualifications, ethics and ability that may bear on his ability to provide quality patient care, including information as to the continuing accuracy of the information required for initial appointment. The burden of providing complete information shall be on the applicant, as in the case of an initial appointment.

B. Verification. The Administrator or designee shall promptly, after the receipt of the information, verify such information as in the case of an initial application. When verification is accomplished and the application is fully complete, the Administrator or designee shall transmit the information to the Chairman of each department in which the appointee requests privileges.

C. Department Action. The Department Chairman shall act on the information and shall promptly furnish his written report and recommendation to the Credentials Committee that the appointment be renewed, renewed with modified staff category or clinical privileges, or terminated, setting forth the reasons therefore if a recommendation is adverse. If he considers it necessary or appropriate, a Department Chairman may request additional information from the applicant concerning his application, and the applicant shall promptly furnish the requested information.

D. Credentials Committee Action. The Credentials Committee shall meet monthly to review the information, reports and recommendations and all other available information on appointees. The Committee shall also consider the results of performance improvement activities to be used in part to determine professional performance and clinical competence. If the Committee considers it necessary or appropriate, it may request additional information from an applicant concerning his application, and the applicant shall promptly furnish the requested information. The Committee shall transmit to the Executive Committee its written report and recommendation as to each appointee, specifying the reasons if the adverse recommendation would deny reappointment, deny change in staff category or clinical privileges, or reduce privileges.

E. Executive Committee Action. The Executive Committee shall review the information, reports and recommendations and all other available information on appointees. If the Committee considers it necessary or appropriate, it may request additional information from an applicant concerning his application, and the applicant shall promptly furnish the requested information. The Committee shall transmit to the Board prior to its monthly meeting a report and recommendation as to each appointee. If the recommendation would deny reappointment, deny a change in staff category or clinical privileges or reduce privileges of an appointee, the report shall set forth the reasons therefore, and in such event the Administrator or designee shall promptly notify the appointee as provided in the Fair Hearing Plan. In such case, the staff member shall be entitled to the procedural rights provided in the Fair Hearing Plan.

F. Board Action. The Board shall act on each request at its next regular meeting, based on the reports, recommendations and other available information pertinent to each applicant. The decision of the Board shall be final, and the notice of the decision shall be transmitted by the Administrator or designee to the Executive Committee and each appointee being considered. Reappointments shall be for a period of two years. The Administrator or designee shall promptly notify the applicant of the final decision of the Board, and, if the decision is a denial, the Administrator or designee shall notify the applicant's licensing board of the denial. If the applicant then so requests in writing, the Board shall furnish the applicant with a writing that sets forth the reasons for the denial.

3. Other.

A. Modifications of Appointment. A staff appointee may, either in connection with reappointment or at any other time, request modification of his staff category, department assignment or clinical privileges by submitting a request in writing to the Administrator or designee. Such requests shall be processed in substantially the same manner as requests for appointment or clinical privileges. If

new or additional privileges are granted, they shall be considered provisional in nature, as in the case of initial privileges granted.

B. Notices. Any notices of adverse decisions on appointments, reappointments or other requests in this Article shall be deemed to have been properly given to the applicant or appointee if in writing and personally delivered with a receipt requested or deposited in the United States Certified or Registered mail, post paid to the address of the applicant or appointee on his application or to his last known address.

C. Time. The time and date deadline set forth in this Article are not exact, but are guidelines for use. All persons or groups shall act promptly.

D. Standards and Procedures of the Board. Notwithstanding any other provision herein, all actions in connection with the consideration of and action upon any application for staff appointments and/or clinical privileges or any request for staff appointment and/or renewal of clinical privileges shall be subject to and in compliance with the then current standards and procedures of the Board for such applications and requests.

E. Geographical Move. Medical staff members who move their primary residence from the geographical area, regardless of their status, must notify the medical staff office within 30 days of the move or voluntarily relinquish their staff membership and clinical privileges.

ARTICLE VII

Clinical Privileges

1. Exercise of Clinical Privileges. Every practitioner or other individual providing clinical services at the Hospital shall, except as expressly provided in these Bylaws, be entitled to exercise only those privileges specifically granted to him by the Board.

2. Admitting Privileges. Only staff members may be granted admitting privileges. The privilege to admit shall be delineated, and is not automatic.

3. General Delineation. Each application of any applicant for appointment and reappointment of clinical privileges must contain a request for the specific clinical privileges desired by the applicant. An application for only clinical privileges shall contain the same information and statements as an application for staff membership. An applicant for clinical privileges shall be subject to the same obligations as are imposed upon an applicant for staff appointment, as provided in Article VI, Sections l and 2. A request by a staff member or allied health professional for a modification of privileges must be supported by documentation of training and experience supportive of the request. Applications and requests for clinical privileges shall be evaluated on the basis of the applicant's, relevant experience, training, performance, current competence, judgment, ability to perform the privileges requested, references, professional liability experience and other relevant information, including an evaluation by the clinical departments in which such privileges have been sought. The criteria for granting clinical privileges shall also include the ability of the Hospital to provide supportive services for the applicant and patients to whom he will provide care and patient care needs for additional persons with the applicants skill and training. The basis for privileges determinations for periodic reappointment or otherwise shall include documentation of observed clinical performance, documented results of patient care evaluation, review of staff records which document the applicant's delivery of medical care, performance improvement activities required by these Bylaws and the Rules and Regulations, and evaluations of the applicant's physical and mental capabilities related to ability to perform the privileges requested. Clinical privileges granted or modified on initial appointment, reappointment or otherwise shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other hospitals and health care facilities where a staff member or allied health professional exercises clinical privileges. The Hospital may, in its discretion, obtain an evaluation of the applicant by a consultant selected by the Hospital. All such information shall be maintained in the individual staff file of the applicant or appointee. Age, sex, race, creed or national origin shall not be used in making decisions regarding the granting or denying of clinical privileges. Any final action on any application for a request for renewal or modification of clinical privileges shall be made by the Board. The Administrator or designee shall promptly notify the applicant and, if the action is a denial, shall notify the applicant's licensing board of such denial. If the applicant then so requests in writing, the Board shall furnish the applicant with a writing that sets forth the reasons for the denial within 30 days of such request.

4. Provisional Privileges. All clinical privileges granted shall initially be considered to be provisional in nature. Each individual who is granted privileges shall be assigned to a clinical department, and his performance shall be observed and evaluated by the department Chairman or his designee. All such grants of privileges shall be for a period of at least one year. This period may be extended for additional six month intervals on the recommendation of the Chairman of the department to which the individual is assigned, if there has not been adequate opportunity to observe his professional performance due to lack of utilization of the Hospital for care of a sufficient number of patients. Any decision to extend the period for provisional privileges shall not be deemed to be adverse action and shall not entitle an individual to the procedures afforded by the Fair Hearing Plan. After completion of the period for which provisional privileges have been granted, such individual may be granted clinical privileges that are for the same period as those granted to other members of the staff, or his privileges shall be terminated. The Chairman of the department to which he is assigned shall submit a report and recommendation concerning such appointee to the Credentials Committee prior to the end of the provisional period. The report and recommendation shall be considered at the next meeting of the Credentials Committee, which shall make a recommendation to the Executive Committee concerning the privileges. The Executive Committee shall consider the recommendation and shall thereafter make its recommendation concerning such privileges to the Board. The Board shall promptly review the Executive Committee recommendation and make its decision concerning the matter.

5. Emergency Privileges. In an emergency, any practitioner, to the extent permitted by his license and regardless of department, staff status or clinical privileges shall be permitted to do and be assisted by Hospital personnel in doing everything possible to save the life of a patient or save the patient from serious harm, using every facility in the Hospital, including calling for any necessary or desirable consultation. Continuing care will be provided by an appropriately credentialed staff member. An emergency shall be considered as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

6. Temporary Privileges.

   A. Circumstances. The granting of temporary privileges may be considered:

      (1) When an applicant with a complete, clean application is awaiting review and approval of the Medical Executive Committee and/or the Board.

      (2) Upon receipt of a request for a duly licensed or certified individual who would qualify for appointment or reappointment to either the medical staff or allied health professional, but is not applying for membership or allied health status at that time, and whose services have been requested to provide specific patient care due to lack of appropriate or available care from a current medical staff member or allied health professional.

   B. Consideration. Upon receipt of the requested documentation recommendation of the department chief and/or chief of staff, and approval by the designated administrator on call may grant temporary privileges for a term of not more than 90 days. During the term of the temporary privileges, the individual must comply with applicable sections of the Bylaws, Rule and Regulations, and Policies and Procedures, and will not be afforded utilization of the Fair Hearing Plan. Upon discovery of any information or the occurrence of any event of a professionally questionable nature about a practitioner or allied health member's qualifications or ability to exercise any of the temporary privileges granted, the Chief of Staff, after a consultation with the department chairman responsible for supervision, may terminate privileges, and such a decision shall be final and non-appealable.

7. Standards and Procedures of the Board. Notwithstanding any other provisions herein, all actions in connection with the consideration of and action upon any application for clinical privileges or any request for a renewal of clinical privileges shall be subject to and in compliance with the then current standards and procedures of the Board for such applications and requests.

ARTICLE VIII

Corrective Action

1. Initiation. Whenever the activities or professional conduct of a staff member having clinical privileges are considered to be, or to be reasonably probable of being, grounds for discipline within the meaning of Section 3 of this Article VIII, corrective action against such staff member may be initiated by any staff officer, any department Chairman, any Chairman of a Medical Staff committee, the Administrator or the Board. All requests for corrective action shall be in writing to the Chief of Staff and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. The Chief of Staff shall notify the Administrator and keep him fully informed of all proceedings and action taken. The Chief of Staff shall also notify the Board, as well as the Chairman of the department in which the questioned activities or conduct occurred, requesting an investigation.

2. Investigation. The Chief of Staff or, at his direction, the Chairman of the department to which the request for an initial investigation is made, shall immediately appoint an ad hoc committee of at least three members of the Active Staff to investigate the matter. The committee may request an interview with the practitioner, and he shall cooperate with the committee in its investigation. As promptly as practicable after the request for investigation is made, but not later than seven days thereafter, the Chairman of the ad hoc committee shall transmit a written investigation report (including a record of any interviews) to the Chief of Staff.

3. Action on Report. As soon as practicable following receipt of the ad hoc committee report, the Chief of Staff shall forward the report to the Executive Committee, which shall take action on the request. If reasonable belief exists that there are any grounds for discipline (as defined herein) of the practitioner with respect to the matter or matters, then the Executive Committee shall determine whether such grounds for discipline do, in fact, exist, and the Executive Committee shall make a recommendation to the Board as to whether such grounds exist and as to action to be taken. The Chief of Staff shall review any such case pending before the Executive Committee and shall excuse from the panel any member of the Executive Committee who, or has a relative who, is in a direct professional or business relationship with the practitioner, is in direct professional or business competition with the practitioner, is a relative of the practitioner, or otherwise has a conflict of interest in the matter which should prohibit such member from participating as contemplated under Section 2 of Article XIV of these Bylaws. For purposes hereof, "grounds for disciplinary investigation" shall include any one or more of the following:

   A. Any activity or professional conduct of the practitioner that:

      (1) Violates these Bylaws, the Hospital Bylaws, the Rules and Regulations of the staff, any applicable clinical department rules and regulations, or any other policies of the Board;

      (2) Is disruptive of Hospital operations;

      (3) Is detrimental to patient safety or the delivery of quality patient care;

      (4) Fails to cooperate with performance improvement, utilization review, or other committee functions when requested;

      (5) Constitutes incompetence; or

   B. The occurrence of:

      (1) The practitioner's being found to be a habitual user of intoxicants or drugs to the extent that he is deemed dangerous to himself or others;

      (2) Mental or physical impairment which may adversely affect patient care;

      (3) The practitioner's being found liable by a court of competent jurisdiction for medical negligence or malpractice involving negligent conduct;

      (4) Reportable liability incidents in accordance with Florida state law; or

      (5) Any other medical negligence of the practitioner.

The practitioner shall be informed of the general nature of the matter and may present relevant information for the consideration of the Executive Committee, and he shall be afforded the opportunity of an interview with the Executive Committee. After determining whether any such grounds exist, the Executive Committee shall notify the practitioner and the Board of the Executive Committee's determination and recommendations in the case, which may include without limitation, recommendations for the following: rejecting the request for corrective action; issuing a warning, a letter of admonition or a letter of reprimand; imposing terms of probation or requirements of consultation; reducing, suspending or revoking clinical privileges. Any adverse recommendation shall entitle the practitioner to the procedural rights afforded by the Fair Hearing Plan, except as provided in the Fair Hearing Plan.

4. Summary Suspension.

   A. Action. Whenever a practitioner willfully disregards these Bylaws or Hospital policies, or whenever his conduct may require that immediate action be taken to protect the life of the patient or to reduce the substantial likelihood of imminent injury to the health or safety of any patient, employee or other person in the Hospital, any one of the following: Chief of the Medical Staff, Chairman of his/her clinical department, or a majority of the Credentials Committee or a majority of the Executive Committee of the Medical Staff, (in that order) shall have the authority whenever action must be taken immediately in the best interest of the patient care in the Hospital to summarily suspend all or any portion of the clinical privileges of a practitioner and such summary suspension shall become effective immediately upon imposition.

   B. Executive Committee Decision. Upon summary suspension of a practitioner, the Executive Committee shall direct that an investigation be conducted by persons designated by the Executive Committee to determine the need for the suspension or further action concerning the practitioner. Within 10 days, the Executive Committee shall conduct a hearing. The Executive Committee may, as a result of the hearing, recommend modification, continuation or termination of the summary suspension, and may take such further action concerning the staff membership and clinical privileges of the practitioner as it considers appropriate. If the investigation is completed within l4 days from the date of the suspension and the investigation does not result in adverse action, as defined in the Fair Hearing Plan, the practitioner shall not be entitled to the procedural rights of the Fair Hearing Plan. If the Executive Committee does not recommend immediate termination of the suspension, or if further adverse action, as defined in the Fair Hearing Plan is taken as a result of the investigation, the practitioner shall be afforded the right to appellate review as provided in the Fair Hearing Plan, but the terms of the summary suspension shall remain in effect pending a final decision by the Board. The Chairman of the Executive Committee or the Chairman of the department to which the practitioner is assigned shall arrange for alternative medical coverage of the suspended practitioner's patients in the Hospital. The wishes of the patient shall be considered in the selection of an alternative practitioner.

5. Automatic Suspensions. If the license or other authorizing legal credential of any practitioner or other professional who is a member of the staff and/or holds clinical privileges is revoked or suspended by a state licensing authority, he shall immediately and automatically be suspended from practicing or providing services in the Hospital by the Executive Committee, and his staff membership (if applicable) and clinical privileges (if applicable) shall automatically be terminated. A practitioner or other professional with clinical privileges who does not maintain compliance with Florida laws regarding professional liability insurance shall be automatically suspended until he furnishes adequate and satisfactory evidence of such compliance. A practitioner who's DEA number is revoked or is suspended from prescribing scheduled drugs as recognized by the DEA shall immediately and automatically be divested of his staff membership and all clinical privileges. In regard to actions restricting a practitioner's right to prescribe non-scheduled drugs, the Executive Committee may consider and take such action as it deems necessary.

6. Medical Records. An automatic voluntary relinquishment of a practitioner's admitting privileges, privileges to give or provide an anesthetic, or privileges to treat or examine patients, as the case may be under the Rules and Regulations, shall be imposed by the Administrator for failure to complete medical records in a timely fashion. The voluntary relinquishment shall continue until the delinquent records are completed, unless there are known extenuating circumstances or the practitioner otherwise satisfies the Administrator that the practitioner has a justifiable excuse for such failure; if the delinquent medical records are not completed in a timely manner, then all clinical privileges of the practitioner shall be

suspended in accordance with the Rules and Regulations. For purposes hereof, justifiable excuses for a failure to complete medical records in a timely fashion include, without limitation, the following:

A. The practitioner's being ill or during the relevant period of time;

B. The unavailability of any other individual who must contribute to the record;

C. The practitioner is waiting for the results of a late report when the record is otherwise complete except for its discharge summary and final diagnosis; or

D. Failure of Hospital personnel to transcribe reports that the practitioner dictated in a timely fashion.

7. Impaired Practitioners Program of Florida. The Impaired Practitioners Program of Florida includes the Physicians Recovery Network (PRN) and is designed to help the individual who has a chemical dependency. The individual seeking referral or referred for assistance will have his confidentiality maintained, except as limited by law, ethical obligation, or when the safety of a patient is threatened. An individual who voluntarily enters the PRN prior to the initiation of an investigation into alleged problems with his practice or behavior will not be subject to disciplinary action by the medical staff because of his impairment. Individual must tell his Department Chief or the Chief of Staff that he is entering the Physicians Recovery Network. At that moment, he agrees to an indefinite voluntary suspension of his privileges. With the help of his Department Chief, arrangements will be made with other physicians to attend his inpatients. He must take a leave of absence.

   Prior to his removal from suspension, he must:

   i. Provide the Executive Committee with a statement from the treating physician in the PRN that he is physically and mentally capable of assuming patient care;

   ii. Follow the rules of Physicians Recovery Network program;

   C. Understand that his hospital practice, privileges, and behavior will be carefully monitored for the safety of his patients until the rehabilitation or any disciplinary process is complete; and

   D. Understand that failure to abide by the provisions in this Bylaw could result in permanent revocation of his clinical privileges.

ARTICLE IX

Clinical Departments

1. Organization. Each department shall be organized as a separate part of the staff and shall have a Chairman approved by the Board with the duties and responsibilities provided in these Bylaws. The clinical departments shall be as follows:

   A. Medicine;

   B. Surgery;

   C. Obstetrics and Gynecology;

   D. Pediatrics; and

   E. Radiology.

2. Assignment to Departments. Each staff member shall be assigned to one department by the Executive Committee upon recommendation of the Credentials Committee, and be granted clinical privileges in one or more other departments in the same manner. The exercise of clinical privileges within any department shall be subject to the rules and regulations of the department and the authority of the department Chairman.

3. Function of Departments. The primary function of each department is to implement specific review and evaluation activities that contribute to the preservation and improvement of quality and efficiency of patient care provided in the department. To carry out this overall function, each department shall:

   A. Require patient care evaluation to be performed for the purpose of improving and/or maintaining the quality of care within the department. Each department shall monitor clinical work performed within the department. The department patient care evaluation shall be conducted at least quarterly through performance improvement mechanisms and other established medical care evaluation processes to include review, evaluations, recommendations and subsequent action on findings relative to patient care within the department concerning:

      (1) Departmental monitors to evaluate important aspects of care, including diagnosis, procedures and patient categories as evidenced by frequency of volume and risk;

      (2) Medical records monitoring;

      (3) Blood usage review;

      (4) Mortality and morbidity review;

      (5) Medication usage review;

      (6) Utilization management;

      (7) Infection control surveillance;

      (8) Operative/invasive and non-invasive case review; and

      (9) Other monitors, as established by each Department.

   B. Establish guidelines for the granting of clinical privileges within the department and submit to the Executive Committee the recommendations required regarding the specific privileges each staff member or applicant may exercise and the specified services that each allied health professional may provide.

   C. Conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in medical practice.

D. Monitor on a continuing basis adherence to:

(1) Staff policies and procedures;

(2) Requirements for alternate coverage and for consultations;

(3) Sound principles of clinical practice; and

(4) Other regulations designed to promote patient safety.

E. Coordinate the patient care provided by the members of the department with nursing and other non-physician patient care services and with administrative support services.

F. Foster an atmosphere of professional decorum within the department appropriate to the practice of medicine.

G. Submit written reports or minutes of department meetings to the Executive Committee on a regular basis concerning:

(1) Findings of the department's review and evaluation activities, actions taken thereon, and the results of such action;

(2) Recommendations for maintaining and improving the quality of care provided in the department and the Hospital; and

(3) Such other matters as may be requested from time to time by the Executive Committee.

H. Meet as often as necessary for the purposes indicated above and for receiving reports on other department and staff functions.

I. Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to the department.

4. Department Officers.

A. Election of Department Chairman.

(1) Each Chairman shall be a member of the active staff qualified by training, experience, and demonstrated ability for the position. The chairman shall be certified by an appropriate specialty board or have demonstrated comparable equivalency through the privilege delineation process.

(2) Each Chairman shall be elected for a two-year term. Medicine and Ob-Gyn will hold elections in odd-numbered years. Surgery, Pediatrics and Radiology will hold elections in even-numbered years. Individual Departments will notify their members as least one month in advance of the impending election. On the day of the election, nominations will be made from the floor, and the nominee receiving the majority votes is elected. A runoff can be held, if necessary. The current chairman can be re-elected subject to the term limit rule. The elected chairman takes office on the first day of January of the next year.

B. Vacancies. In the event the Chairman of the department is unable to serve, or resigns or is removed, the Executive Committee shall appoint a Chairman to serve the remainder of his term. Any other vacancies and department offices shall be filled in the same manner as initial appointments.

C. Resignations and Removals. Any department officer may resign at any time by giving written notice to the Executive Committee and, unless specified therein, the acceptance of such resignation shall not be necessary to make it effective. Any department officer may be removed by the Board upon the recommendation of the Executive Committee. A request for the removal of a department officer may be made by at least one-half of the active staff directly to the Board, specifying in writing the reason for the request. The Board shall take such action concerning the request as it deems appropriate.

D. General duties of Chairman. Each department Chairman shall be responsible for the organization of the department and delegation of duties to department members to promote the best interest of patients. Members of departments shall be responsible to department Chairman as chief of the service and, through him, to the Chief of Staff. Each department Chairman is responsible for the following:

(1) All clinically related activities of the department;

(2) All administratively related activities of the Department, unless otherwise provided for by the hospital;

(3) The integration of the department into the primary functions of the organization;

(4) The coordination and integration of interdepartmental and intradepartmental services;

(5) The development and implementation of policies and procedures that guide and support the provision of services;

(6) The recommendations for a sufficient number of qualified and competent persons to provide care;

(7) Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department;

(8) Recommending to the medical staff the criteria for clinical privileges in the department;

(9) Recommending clinical privileges for each member of the department;

(10) The determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services;

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

(12) Recommendations for space and other resources needed by the department.

5. Clinical Privileges. Subject to Article VII, each department shall establish its own criteria and shall define and delineate privileges for its members, consistent with these Bylaws and the policies of the staff and the Board, for the granting of clinical privileges. Such definition and delineation shall be approved by the Executive Committee and the Board. Each department chairman shall recommend to the Credentials Committee the clinical privileges for practitioners assigned to the department and for those requesting only clinical privileges in the department and recommendations concerning appointment, reappointment, classification and delineation of clinical privileges or special services and corrective action.

ARTICLE X

Officers

1. Officers. The officers of the staff shall be the Chief of Staff, Chief of Staff Elect and Secretary/ Treasurer. Officers must be members of the Active Staff at the time of nomination and election and must continuously maintain such status during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

2. Nominations and Elections. Prior to the annual staff meeting, the Nominating Committee shall convene and submit to the Chief of Staff one or more qualified nominees for each office. The Nominating Committee shall report the names of the nominees to the staff at least l4 days before the annual meeting. Nominations may also be made from the floor at the time of the annual meeting. Voting at the annual meeting shall be by open ballot. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for an office receives a majority vote, a runoff election by ballot shall be held at the meeting between the two candidates receiving the highest number of votes. If a tie results, the deciding vote shall be cast by the presiding officer. The election shall become effective upon approval of the Board.

3. Term. Officers shall be elected for a term of one calendar year and until their successors are duly elected and have qualified. A vacancy in any office shall be filled by the Executive Committee for the unexpired portion of the term, subject to the automatic succession of the Chief of Staff Elect as provided herein. No person may serve in the same position for more than two consecutive terms.

4. Resignations and Removals. Any officer may resign at any time by giving written notice to the Executive Committee and, unless specified therein, the acceptance of such resignation shall not be necessary to make it effective. Any officer may be removed by a vote of a majority of the active medical staff a special meeting called for such a purpose. A petition for removal shall be submitted to the Board by at least 30% of the Executive Committee and, upon receipt thereof, a meeting of the Executive Committee shall be called to be held within 30 days to consider and act upon the petition. An officer shall be removed upon receiving at least a majority of the valid votes cast at the meeting of the Executive Committee in favor of removal. If an officer resigns or is removed, his successor shall be filled in the same manner as any other vacancy.

5. Chief of Staff. The Chief of Staff shall serve as Chief Administrative Officer of the staff and shall have general overall supervision of the affairs of the staff. He shall:

   A. Assist in coordinating the activities of the Administration, the nursing staff, allied health professional and other non-physician patient care services with those of the staff;

   B. Call, preside at and be responsible for the agenda of staff meetings;

   C. Be responsible to the Administration and the Board for the quality and efficiency of clinical services and professional performance in the Hospital and the effectiveness and quality of patient care;

   D. Develop and implement, in conjunction with department Chairmen and Hospital personnel, methods for credentials review, delineation of privileges, educational programs, utilization review and performance improvement;

   E. Communicate and represent the opinions, policies, concerns, needs and grievances of the staff to the Administrator and the Board;

   F. Be responsible for enforcement of these Bylaws and the Rules and Regulations, implementation of sanctions as needed and staff compliance with procedures in all instances when corrective action has been requested or taken against a practitioner;

   G. Act as representative of the staff to the public, as well as to other health care providers, other organizations, the Administration, the Board, and government and voluntary organizations;

   H. Appoint and discharge Chairmen and members of all staff committees, except the Executive Committee and the Nominating Committee, and serve as ex officio member of all staff committees;

I. In the absence of the Chief of Service, he should designate another staff member who is willing to assume his duties during the absence;

J. Receive and interpret the opinions, policies and directives of the Administration and the Board to the staff;

K. Serve as Chairman of the Executive Committee; and

L. Perform all duties incident to the function of principal administrative officer of the staff.

6. Chief of Staff Elect. The Chief of Staff Elect shall perform the duties of the Chief of Staff in the absence or inability of the Chief of Staff to perform. He shall serve as Chairman Elect of the Executive Committee and shall perform such additional duties as may be assigned by the Chief of Staff or the Board. He shall serve as chairman of the Nominating Committee. In the absence of the Chief of Staff, he should assume those duties.

7. Secretary/Treasurer. The Secretary/Treasurer or his designee, shall, subject to the direction of the Chief of Staff

A. Keep the minutes of staff meetings;

B. Assure that all notices of staff meetings are given as provided in these Bylaws;

C. Be custodian of staff records and ledgers; and

D. In general, perform all duties incident to the office of Secretary/Treasurer and such other duties as may be assigned by the Chief of Staff.

ARTICLE XI

Committees

1. Committees.

   A. Standing Committees. The Standing Committees shall be:

      (1) Executive Committee;

      (2) Bylaws Committee;

      (3) Nominating Committee; and

      (4) Credentials Committee;

      Members of the Standing Committees shall be appointed and removed in the same manner as members of ad hoc committees, except as specifically provided in these Bylaws or as otherwise recommended by the Executive Committee and approved by the Board.

   B. Tenure. Except as otherwise expressly provided in these Bylaws, each member of a standing committee shall be appointed for a term of one year, and until his successor is appointed or elected, unless sooner removed. Members of ad hoc committees shall be appointed for similar terms, unless the committee is established for a specified lesser period of time. Vacancies on any staff committee shall be filled in the same manner in which the original appointment to such committee is made.

   C. Executive Committee.

      (1) Composition. The Executive Committee shall consist of:

         (a) Chief of Staff, Chief of Staff Elect, and Immediate Past Chief of Staff, if such persons are available and capable of serving;

         (b) Chairman of all clinical departments or their designees; and

         (c) Secretary/Treasurer.

         The Chief of Staff shall serve as Chairman. The Administrator shall serve as an ex officio member.

      (2) Responsibilities and Authority. The Executive Committee shall meet at least monthly and shall maintain a permanent record of its proceedings and actions. The Committee shall consider and act on all matters affecting the staff and shall act on behalf of the staff in intervals between staff meetings, subject to the limitations of these Bylaws, and shall:

         (a) Coordinate the activities and general policies of staff committees and clinical departments;

         (b) Receive and act on committee and department reports;

         (c) Implement staff policies which are not otherwise the responsibility of the departments;

         (d) Provide liaison between the staff and the Administrator, and between the staff and the Board;

         (e) Recommend action on matters of a medical administrative nature to the Board;

         (f) Make recommendations on matters of Hospital management to the Board;

         (g) Account to the Board for the overall quality and efficiency of medical care provided to patients in the Hospital by the Medical Staff;

(h) Keep the staff abreast of the accreditation program and the accreditation status of the Hospital;

(i) Assist the Board, and recommend to the Board all matters concerning staff, reappointments, department assignments, delineations of privileges, specified services, and corrective action, based on recommendations of the Credentials Committee;

(j) Take all reasonable steps to insure professionally ethical conduct and competent clinical performance by all staff members, including the initiation of, and participation in, corrective action and review measures when warranted;

(k) Evaluate the effectiveness of staff committees and take appropriate action to improve or terminate them;

(l) Report on its activities at staff meetings;

(m) Review and evaluate reports concerning the competence, conduct and clinical performance of allied health professionals;

(n) Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs; and

(o) Provide for annual financial audit of Medical Staff funds.

(3) Performance Improvement. The Executive Committee shall insure that provisions are made for the effective performance of staff functions as required in these Bylaws whereas the Board may reasonably require, and for the adequacy of the Hospital's performance improvement plan.

D. Bylaws Committee. The Bylaws Committee shall be composed of five members; four are appointed for four-year staggered terms by the Chief of Staff. The Chief of Staff Elect (President Elect) is an ex-officio member. Annually, the committee will elect a chairman. It shall meet at least annually to review these Bylaws and the Rules and Regulations and recommend to the Executive Committee or directly to the Board any needed additions, revisions, modifications, amendments or deletions. The Bylaws Committee shall also review all department rules and regulations.

E. Nominating Committee. The Medical Executive Committee will serve as Nominating Committee. It will nominate one or more members for Chief of Staff elect and Secretary/Treasurer. It will consult with the nominees concerning their qualifications and willingness to serve, prepare ballots and supervise the election of these officers. Each department shall elect a member of the department to serve as chairperson for the following year.

F. Credentials Committee.

a. Composition and Duties. The Credentials Committee shall consist of the five past Chiefs of Staff. One of these members shall serve as Chairman. The Committee shall meet monthly and on call of the Chairman and investigate the character and qualifications of all applicants for membership of the staff and clinical privileges and shall bi-annually verify the current licensure of all staff members and others with clinical privileges in the Hospital. The Committee shall submit at the regular and other meetings of the Executive Committee a report of its findings and recommendations with regard to appointments, reappointments, modifications of appointments, and suspensions and revocations of appointments to the staff and privileges to be granted, modified, suspended or revoked. Additionally, the Committee shall investigate the character and qualifications of all allied health professionals who apply to render specified services and shall make recommendations concerning their applications. The Committee also shall submit to the Executive Committee a report of its recommendations with regard to:

(a) Associate Staff members and grants or extensions of provisional privileges;

(b) Privileges to be granted to physicians employed on a part time basis in the Emergency Department; and

(c) Privileges to be granted to health care professionals other than practitioners.

b. Appointments and Reappointments. The Committee shall submit to the Executive Committee recommendations with regard to reappointment of staff members, along with any recommendations it may have regarding changes in staff status or clinical privileges. The recommendations of the Committee shall be based upon:

(a) A review of the performance of staff members;

(b) Attendance of staff and committee meetings;

(c) Hospital utilization;

(d) Comments regarding staff members received from the ad hoc committees; and

(e) A review of recommendations from the chairmen of the clinical departments, which shall include consideration of the physical and mental capabilities of those members as it relates to their ability to perform the privileges requested.

The Committee shall also review and evaluate the qualifications, competence and performance of allied health professionals and provisional status appointees and make recommendations with respect thereto. The Committee shall investigate, review, and report on matters involving clinical or ethical misconduct of any practitioner.

G. Continuing Committees. The continuing committees shall discharge such responsibilities that may be assigned in addition to various staff functions as described in Section C, Committee Functions. Chief of Staff shall appoint the members of continuing committees and shall designate a Chairman. Members of committees need not be staff members or practitioners. Any member of a continuing committee may be removed by the Chief of Staff whenever, in his judgment, the best interests of the staff and/or hospital will be served by such removal.

H. Ad Hoc Committees. Ad Hoc Committees may be created and abolished by the Chief of Staff. The Ad Hoc Committees shall discharge such responsibilities as may be assigned to them. The Chief of Staff shall appoint the members of the Ad Hoc Committees and shall designate a Chairman, and secretary of each committee. Members of committees need not be staff members or practitioners. The Chief of Staff may from time to time appoint one or more additional persons as ex officio non-voting member(s) of Ad Hoc Committees. Administrative staff appointments shall be made after consultation with, and approval of, the Administrator. Any member of any Ad Hoc Committee may be removed by the Chief of Staff whenever, in his judgment, the best interests of the staff and/or Hospital will be served by such removal.

2. Committee Meetings:

A. Notice. Notice of a committee meeting may be given in the same manner as notice for medical staff and department meetings, but, in addition, notice for a committee meeting may be given orally and may be given not less than three days before the meeting.

B. Quorum. A quorum is 50% of active staff members on the committee. No action of a committee shall be valid unless taken at a meeting at which a quorum is present. If less than such numbers are present, a majority of the active staff members present may adjourn the meeting from time to time without further notice until a quorum is present.

C. Procedures. Each committee may formally or informally adopt its own rules of procedure, which shall not be inconsistent with the terms of its creation or these Bylaws or Roberts Rules of Order.

D. Committee Composition and Functions. The composition and functions, including duties and responsibilities of the committees shall be defined in these Bylaws or a separate notebook maintained by the staff and the committee. The composition and functions of committees shall be consistent with the provisions of these Bylaws.

E. Reports. The secretary of each committee shall prepare minutes or reports of each meeting and forward copies thereof to its reporting authority. A copy of all reports, records and evaluations of each committee shall be kept and maintained in the minutes of the committee.

F. Rules of Order. In absence of specific rules or terminology in these Bylaws or Rules and Regulations, the most recent edition of Roberts Rules of Order will prevail.

3. Committee Functions.

A. Pharmacy, Therapeutics, and Nutrition. The duties involved in developing and maintaining surveillance of medication utilization policies and practice are to:

(1) Assist in the formulation of policies regarding the evaluation, appraisal, use, safety procedures and all other matters relating to drugs in the Hospital;

(2) Make recommendations concerning drugs to be stocked on the nursing units and by other services;

(3) Develop and review periodically a formulary or drug list for use in the Hospital;

(4) Review in detail all reported drug reactions, drug errors and recommend corrective action;

(5) Review all data relative to drug effectiveness, side effects and new drugs or uses, and disseminate such information as needed;

(6) Prepare at least quarterly a report consisting of statistical data involving drug reactions and drug errors, their probable causes and actions taken to resolve problems and follow-up actions to assure the resolution of problems;

(7) Establish standards concerning the use and control of investigational drugs and a free search and use of recognized drugs; and

(8) Perform such other duties as assigned by the Chief of Staff.

Documentation of the performance of this function shall be reflected in the appropriate committee minutes on at least a quarterly basis.

B. Medication Usage Evaluation. The duties involved in performing the review of the clinical use of drugs, including antibiotics will be carried out according to the processes described in the Performance Improvement Plan. These functions include:

(1) Conduct studies to review the prophylactic use of drugs for inpatients, ambulatory care and emergency care patients;

(2) Establish criteria for the prophylactic and therapeutic use of drugs in problem areas and review variations from criteria; and

(3) Take necessary action and assure resolution of problems.

Documentation of the performance of this function shall be reflected in the appropriate committee minutes on at least a quarterly basis.

ARTICLE XII

Meetings

1. Regular Meetings. A regular meeting of the staff shall be held quarterly at a time and place designated by the Executive Committee for the purpose of receiving reports from officers and committees. The last quarterly meeting of the year, termed “The Annual Meeting,” shall be held for electing officers and transacting such other business as may properly come before the meeting.

2. Special Meetings. Special meetings of the staff may be called at the direction of the Chief of Staff and shall be called by the Chief of Staff at the request of the Executive Committee or any ten members of the active staff by written request to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these bylaws.

3. Notice. Notice of the date, time, and place of any meeting shall be given not less than 14 nor more than 30 days prior to a regular meeting and not less than five nor more than l0 days prior to a special meeting by notice delivered through normal distribution channels to each member of the active staff. The Executive Committee or the Chief of Staff may send notice to members of other categories of the staff, the Administrator, members of the Administration and others. Any member may waive notice of any meeting in writing. The attendance of any member at a meeting shall constitute a waiver of notice at the meeting, except when a member attends a meeting for the express purpose of objecting at the beginning of the meeting to the transaction of any business because the meeting is not lawfully called or convened.

4. Quorum. A quorum is 30%, based on the active staff membership of the group on January 1 of the calendar year. If less than such numbers are present, a majority of the voting active staff members present may adjourn the meeting from time to time without further notice until a quorum is present.

5. Manner of Acting. The act of a majority of voting active staff members present shall be the act of the staff except where a two-thirds majority of voting members is required. Members may not vote by proxy. No action of the members shall be valid unless taken at a meeting at which a quorum is present.

6. Minutes. The Secretary or designee shall prepare minutes of each meeting, which shall include a record of attendance and the votes taken on each matter. Minutes shall be signed by the Secretary, approved by the presiding officer and maintained in a permanent file. Minutes shall be available for inspection by staff members for any proper purpose subject to any policies concerning confidentiality of records and information.

7. Procedures. The Chief of Staff or in his absence, the Chief of Staff Elect shall preside at staff meetings. Meetings shall be conducted in an orderly manner.

8. Required Attendance. Each Active and Associate staff member is required to attend at least 50% of all staff meetings and Department meetings to which he/she is assigned in each year. If a staff member must be absent, he must promptly contact the Medical Staff Office stating the reason for his excused absence. Unless excused for good cause, failure to attend staff meetings will result in a fine as specified by the medical staff.

9. Special Appearance. If a patient's clinical course of treatment is scheduled for discussion, the practitioner treating the patient shall be notified by the Chairman of the appropriate department when at least l4 days advance written notice of the time and place of the meeting to the practitioner. If apparent or suspected deviation from standard clinical practices is involved, the notice shall also include a statement of the issue involved and that the practitioner's attendance is mandatory. Failure of the practitioner to appear when attendance is mandatory, unless excused for good cause by the Chairman, shall be grounds for automatic suspension of the practitioner's clinical privileges or other appropriate corrective action.

10. Roberts Rules of Order. In absence of specific rules or terminology in these Bylaws or Rules and Regulations, Roberts Rules of Order will prevail.

ARTICLE XIII

Privileges and Immunities

1. Agreement of Applicants and Practitioners. Any applicant for staff privileges, and every practitioner and member of the staff, and everyone having or seeking privileges to practice his profession or to render specified services in the Hospital agrees that the provisions of this Article shall specifically control with regard to his relationship to the staff, other members of the staff, members of the Board, and the Hospital. By submitting an application for membership, by accepting appointment to the staff or clinical privileges, by exercising staff privileges, including temporary privileges, and by seeking to render and rendering specified services, each practitioner and each allied health professional specifically agrees to be bound by the provisions of this Article during the processing of his application and at any time thereafter, and they shall continue to apply during his appointment or reappointment.

2. Privileges. Any act, communication, report, recommendation or disclosure concerning any applicant for staff membership, clinical privileges or specified services performed, given or made by any practitioner or member of the staff in good faith and without actual malice and at the request of any authorized representative of the staff, the Administration, the Board, the Hospital or any other health care facility or provider for the purpose of providing, achieving or maintaining quality patient care in the Hospital or at any other health care facility shall be privileged to the fullest extent permitted by law. Such privileges shall extend to members of the staff, the Administrator, Administration officials, Board members and their representatives and to third parties who furnish information to any of them to receive, release or act upon such information. Third parties shall include individuals, firms, corporations and other groups, entities or associations from whom information has been requested or to whom information has been given by a member of the staff, authorized representatives of the staff, the Administration or the Board.

3. Immunity. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed, given or made, even if the information involved would otherwise be privileged. No action, cause of action, damage, liability or expense shall arise or result from or be commenced with respect to any such act, communication, report, recommendation or disclosure. Such immunity shall apply to acts, communications, reports, recommendations and disclosures performed, given or made in connection with or for or on behalf of any activities of any other health care facility or provider including, without limitation, those relating to:

    A. Applications for appointment to the Medical Staff or for clinical privileges or specified services;

    B. Periodic appraisals or reviews for reappointments, clinical privileges or specified services;

    C. Corrective action or disciplinary action, including suspensions or revocations of clinical privileges or staff membership or licenses to practice medicine;

    D. Hearings and appellate review;

    E. Medical care evaluations;

    F. Peer review evaluations;

    G. Utilization reviews; and

    H. Any other hospital, departmental service or committee activities related to quality patient care, professional care, professional conduct or professional relations. Such matters may concern, involve or relate to, without limitation, such persons' professional qualifications, clinical competency, character, fitness to practice medicine, physical condition, ethical or moral standards or any other matter that may or might have an effect or bearing on patient care.

4. Release. In furtherance of and in the interest of providing quality patient care, each applicant for clinical privileges or specified services, practitioner, member of the staff and allied health professionals shall, by requesting or accepting staff privileges or specified services, release and discharge from loss, liability, cost, damage and expense, including reasonable attorney's fees, such persons who may be entitled to the benefit of the privileges and immunities provided in this Article, and shall, upon request of the

Hospital or any officer of the staff, execute a written release in accordance with the tenor and import of this Article.

5. Non-Exclusivity. The privileges and immunities provided in this Article shall not be exclusive of any other rights to which those who may be entitled to the benefit of such privileges and immunities may be entitled under any statute, law, rule, regulation, bylaw, agreement, vote of members or otherwise, and shall enure to the benefit of the heirs and legal representatives of such persons.

ARTICLE XIV

General Provisions

1. Rules and Regulations. Subject to the approval of the Board, the medical staff shall adopt such rules and regulations as may be necessary to implement these Bylaws. The Rules and Regulations shall relate to the proper conduct of staff organizational activities and shall embody the level of practice required of each staff appointee.

2. Department Rules and Regulations. Subject to the approval of the Executive Committee and the Board, each department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws and the Rules and Regulations of the staff or other policies of the Hospital.

3. Professional Liability. Each practitioner and other individuals granted clinical privileges or approved to render specified services in the Hospital shall be responsible for professional liability as may be required by Florida Statutes.

4. Forms. Application forms and other prescribed forms required by these Bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports and other matters shall be prepared by the Executive Committee, subject to approval of the Board.

5. No Implied Rights. Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy or right of action upon any person, except as expressly set forth herein, and except as expressly provided in Article XIII. These Bylaws and the Rules and Regulations are intended for internal Hospital use only. No person is authorized to rely on any provisions of these Bylaws or the Rules and Regulations except as specifically provided herein, and no person may personally enforce any provision hereof, except as specifically provided. These Bylaws and the Rules and Regulations are intended for professional internal use and governance only.

6. Pronouns. All pronouns and any variations thereof in these Bylaws and Rules and Regulations shall be deemed to refer to the masculine, feminine, or neuter, singular or plural as to the identity of the person or persons may require, unless the context clearly indicates otherwise.

7. Notices. Any notices, demands, requests, reports or other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally or deposited in the United States first class mail, post-paid, to the person entitled to receive notice at his last known address, except as otherwise provided in these Bylaws or in the Rules and Regulations.

8. Distribution. The officer of the staff shall insure that a copy of these Bylaws and the Rules and Regulations, and all amendments thereto, are given to each applicant for privileges and each member of the staff and are continuously available to members of the staff upon request; provided, a reasonable charge may be imposed for copies given to persons who request more than one copy.

9. No Contract Intended. Notwithstanding anything herein to the contrary, it is understood that these Bylaws and Rules and Regulations do not create, nor shall they be construed as creating, in fact, by implication or otherwise a contract of any nature between or among the Hospital or the Board or the staff and any member of the staff or any person granted clinical privileges who are entitled to perform specified services. Any clinical or other privileges are simply privileges which permit conditional use of the Hospital facilities, subject to the terms of these Bylaws and the Rules and Regulations. Any provisions of these Bylaws may be amended, altered, modified or repealed at any time as provided herein. Notwithstanding the foregoing, the provisions of Article XIII, Article V, Part C, Section 2, and other provisions pertaining to undertakings in the nature of an agreement or an indemnity or a release shall be considered contractual in nature, and not a mere recital and shall be binding upon practitioners, staff members and those granted clinical privileges in the Hospital.

10. Confidentiality. Members of the staff shall respect and preserve the confidentiality of all communications and information relating to credentialing, peer review and performance improvement activities. Any breach of this provision, except as required by law, shall subject the staff member to corrective action.

11. Conflicts of Interest. Practitioners shall disclose any conflict of interest or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his participation on any committee or in his activities in medical staff affairs, including in departmental activities and in the review of cases. Where such a conflict of interest exists or may arise, the practitioner shall not participate in the activity or, as appropriate, shall abstain from voting, unless the circumstances clearly warrant otherwise. This provision does not prohibit any person from voting for himself nor from acting in matters where all others who may be significantly affected by the particular conflict of interest consent to such action.

12. Entire Bylaws. These Bylaws are the entire Medical Staff Bylaws of the Hospital and supersede any and all prior Medical Staff Bylaws which, by adoption hereof, shall be automatically repealed.

13. Fair Hearing Plan. The Medical Executive Committee on an annual basis shall review and evaluate the mechanism by which medical staff membership may be terminated and the mechanism for Fair Hearing procedures. Evaluation shall include review of actions taken as a result of the hearing process to assure all medical staff members are treated equitably as defined in Article VIII as it relates to the Fair Hearing process.

14. Adoption and Amendments. These Bylaws, Rules and Regulations, and a Fair Hearing Plan, shall be adopted when approved by the Board, after consulting with the Executive Committee. (Amendments, revisions, modifications and restatements of these Bylaws may be proposed by any clinical department, committee or member of the staff.) Such proposals will be referred to the Bylaws Committee for evaluation. The Bylaws Committee will review the proposals and submit their recommendations to the Executive Committee prior to presentation at the next Quarterly or Special Medical Staff meeting. Any proposed Bylaw amendment will be presented in writing to the Active Staff at least l5 days prior to said meeting. If approved by the staff and the Board, the proposal shall become effective. Neither body may unilaterally amend the Bylaws.

15. Rules and Regulations. Rules and Regulations may be amended similar to the Bylaws, except they require a simple majority for passage at a quarterly or special medical staff meeting. Any amendments become effective when approved by the staff and the Board.

16. Standards and Procedures. These Bylaws, together with any additional policies that may be provided by the Board from time to time, shall constitute the standards and procedures provided by the Board with respect to application for and requests for renewals of staff membership and/or clinical privileges.

GULF COAST MEDICAL CENTER
FAIR HEARING PLAN – APPENDIX A

ARTICLE I

Medical Staff

GENERAL

1. Purpose. This document sets forth the Fair Hearing Plan for the Hospital. The provisions of this document are subject to the provisions of the Medical Staff Bylaws. The terms defined in the Medical Staff Bylaws shall have the same meanings herein.

2. Adoption and Amendments. This document may be adopted, amended, revised, modified, restated and repealed in the manner set forth in the bylaws.

3. Distribution. A copy of this document and all amendments and modifications shall be maintained in the Staff records, the records of each committee and the records of each department.

4. Application. Those practitioners who are credentialed by the medical staff are entitled to mechanisms afforded by the Fair Hearing Plan.

INITIATION OF HEARING

1. Adverse Action.

   A. Adverse recommendations or actions on the following shall entitle the practitioner affected thereby to a hearing:

      (1) denial of initial staff appointment;

      (2) Denial of reappointment;

      (3) Suspension of Staff membership;

      (4) Revocation of Staff membership;

      (5) Denial of advance in Staff category;

      (6) Limitation of the right to admit patients;

      (7) Denial of requested department assignment;

      (8) Denial of requested clinical privileges;

      (9) Reduction in clinical privileges;

      (10) Suspension of clinical privileges;

      (11) Revocation of clinical privileges; and

      (12) Individual requirement of consultation.

   B. Adverse recommendations or actions on the following shall not entitle the practitioner affected thereby to a hearing:

      (1) Denial of temporary privileges or denial of the temporary provision of specified services;

      (2) Extension of provisional privileges for one or more additional periods;

(3) Denial, suspension, revocation or limitation of appointment or the ability to provide specified services by an Allied Health Professional, except as provided in the bylaws;

(4) Reduction or termination of privileges in accordance with the terms of a contract with the Hospital under which the practitioner is rendering service; and

(5) Summary suspension for a period of not longer than 14 days during which an investigation is being conducted, as provided in the bylaws.

C. When Deemed Adverse. A recommendation or action shall be deemed adverse only when it has been:

(1) Recommended by the Executive Committee;

(2) Taken by the Board; or

(3) In the case of summary suspension, taken by the anyone entitled to summarily suspend privileges, except that if a summary suspension is in effect for 14 days or less, during which an investigation is conducted, such suspension, of itself, shall not entitle the practitioner affected thereby to a hearing. The issuance of a warning, a request to appear before a committee, a letter of admonition, a letter of reprimand and the denial termination or reduction of temporary privileges shall not constitute adverse action. Discharge by the Hospital of a physician as an employee may be accomplished in accordance with usual Hospital employment policies and shall not of itself constitute adverse action.

D. Interviews. When the Executive Committee is considering initiating an adverse recommendation concerning a practitioner, the practitioner may be afforded an interview. An interview shall not constitute a hearing, shall be preliminary in nature and shall not be conducted in accordance with the procedural rules of this Fair Hearing Plan. The practitioner shall be informed of the general nature of the matter and may present relevant information. A record of the interview shall be made.

E. Notice of Action. A practitioner shall promptly be given written notice of an adverse recommendation or action against him. The notice of adverse recommendation or action shall state:

(1) That an adverse recommendation or action has been made or is proposed to be made or taken against him;

(2) The reasons for the action or recommendation;

(3) That he has a right to request a hearing on the action or recommendation in accordance with the bylaws at any time within 30 days after receipt of the notice;

(4) That failure to request a hearing shall constitute a waiver of a right to a hearing and the appellate review;

(5) That if a hearing is requested on a timely basis, he will be given further notice stating the time, place and date of the hearing, which date will not be less than 30 days after the date of the further notice, and a list of witnesses, if any, expected to testify at the hearing on behalf of the Hospital or the professional review body.

(6) Also, the notice of adverse action or recommendation shall state that if a hearing is requested on a timely basis, in the hearing, the practitioner has the right to:

(a) Representation by an attorney or other person of his choice;

(b) Have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof;

(c) Cross-examine witnesses;

(d) Present evidence determined to be relevant by the hearing officer or panel, regardless of its admissibility in a court of law;

(e) Submit a written statement at the close of the hearing; and

(f) Upon completion of the hearing, to receive the written recommendation of the hearing officer or panel, including a statement of the basis for the recommendations, and to receive a written decision of the Hospital, including a statement of the basis for the decision.

F. Request and Waiver. A practitioner shall have 30 days following his receipt of notice of adverse action to request a hearing. The request shall be given in writing to the C.E.O by personal delivery or by certified or registered mail and shall be deemed given when received by the C.E.O. Failure to timely request of a hearing shall constitute a waiver of the hearing and of any review. In case of a waiver of an adverse recommendation by the Executive Committee, the recommendation shall become effective pending final decision by the Board. The Board shall consider the recommendation at its next regular meeting, and if the Board is in accord with the recommendation, its decision shall be final. If the Board action has the effect of changing the Executive Committee's recommendation, the matter shall be submitted to a joint conference as provided in the case of appellate review. The Board action on the matter following receipt of the joint conference recommendation shall constitute its final decision. Administration shall promptly notify the practitioner of his status.

HEARING PREREQUISITES

1. Notice and Time for Hearing. Within ten days after receipt of a request for a permitted hearing, the Executive Committee shall schedule and arrange for a hearing. Administration shall send notice to the practitioner of the place, time and date of the hearing at least seven days prior thereto. The hearing date shall be not less than 30, nor more than 60 days, from receipt of the request, but in any event not less than 30 days after the date of the notice of the adverse action initially sent; provided, a hearing for a practitioner who is under suspension then in effect shall be held as soon as arrangements for it may reasonably be made, but not later than 15 days from the date of receipt of the request. The notice shall contain a list of the specific or representative patient records in question or other reasons or subject matter forming the basis for the adverse recommendation or action. Also, the notice shall contain a list of the witnesses, if any, expected to testify at the hearing on behalf of the Staff, and shall require that a list of witnesses expected to testify on behalf of the practitioner be submitted within 10 days. The notice may state that the Staff or the hospital, as the case may be, reserves the right to amend the lists of documents, information and witnesses and, if amended, prompt notice of any amendment will be given to the practitioner. Request for postponement of a hearing shall be permitted only upon mutual agreement of the practitioner and the hearing panel.

2. Hearing Officer or Panel. The hearing shall be held before a hearing officer or a panel of individuals who are appointed by the Executive Committee and are not in direct economic competition with the practitioner involved. The Executive Committee shall determine whether to utilize a hearing officer or a hearing panel. If a hearing panel is utilized, the Chairman of the Executive Committee may designate a hearing officer from the members of the hearing panel. At least a majority of the members of the hearing panel must be present during the hearing. Also present shall be the chairman of the department in which the petitioner is seeking privileges or is assigned, or in his absence or disqualification, another active member of such department appointed by the chairman of the Executive Committee. A person shall be disqualified from serving as a hearing officer or on a hearing panel if he has participated in initiating or investigating the matter at issue or if he is in direct economic competition with the practitioner involved.

HEARING PROCEDURE

1. Presence at Hearing. The personal presence of the practitioner who requested the hearing shall be required. His failure without good cause to appear and proceed shall constitute a waiver of his right to a hearing and an acceptance of the adverse recommendation or action, which shall become effective immediately. The practitioner who requested the hearing shall be entitled to representation by an attorney or other person of his choice, and have a record made of the proceedings, copies of which may be obtained by him upon payment of any reasonable charges associated with the preparation thereof. The Hospital shall also be entitled to be represented by an attorney of its choice and shall designate one

or more persons to represent the facts in support of the adverse recommendation or action and examine witnesses. The hearing officer shall maintain decorum and ensure that all participants have an opportunity to present relevant oral and documentary evidence. The hearing officer shall determine the order of procedure and make rulings on issues and matters.

2. Conduct of Hearing. During the hearing, the parties shall have the right to call and examine witnesses, introduce exhibits, cross-examine witnesses on relevant matters, impeach witnesses and rebut evidence. If the practitioner who requested the hearing does not testify in his own behalf, he may be called and examined. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence, and the parties may present evidence determined to be relevant by the hearing officer, regardless of its inadmissibility in a court of law. The hearing officer may request that oral evidence by taken only on oath or affirmation administered by a person entitled to notarize documents. The practitioner who requested the hearing shall have the burden of providing, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that the conclusions drawn are arbitrary or capricious. A record or sufficiently accurate summary of the hearing shall be kept. The hearing officer or hearing panel may select the method to be used for making the record. The hearing panel may recess, adjourn and reconvene without further notice for the convenience of the participants or to obtain additional evidence or consultation. At the conclusion of the presentation of evidence, the hearing shall be closed. The parties may, at the close of the hearing, submit a written statement. The hearing panel shall then, at a time convenient to itself, privately conduct its deliberations, reach a decision and adjourn.

3. Hearing Report. Within 14 days after adjournment, the hearing panel shall prepare a written report of its findings and recommendations, including a statement of the basis for the recommendations, and forward it to the Administrator. The Administrator shall immediately send written notice of the recommendations, including a statement of the basis for the recommendations, to the practitioner, all members of the hearing panel and the Board. If the result is favorable to the practitioner, the result shall become final, subject to Board approval. If the result continues to be adverse to the practitioner the notice to him shall inform him of his right to request appellate review within ten days following receipt of the notice.

4. Board Initiation of Action. When the initial adverse action is taken by the Board, rather than by the Executive Committee or by a person entitled to summarily suspend privileges, the procedures set forth in this Fair Hearing Plan shall be followed as in the case of adverse action taken or recommended in other situations. Provided in such event the Board may elect to act in lieu of the Executive Committee in all hearing prerequisites and hearing procedures. Further, in such event the decision of the Board shall be final, without appellate review.

INITIATION OF APPELLATE REVIEW

1. Request for Appellate Review. A practitioner shall have ten days following his receipt of notice of an adverse result by the hearing panel to request appellate review by the Board. The request shall be given in writing to the Administrator by personal delivery or by certified or registered mail and shall be deemed given when received by the Administrator. The request may provide that the Board review only the record on which the adverse recommendation is based and may also state that the petitioner requests oral argument. Failure to timely request appellate review shall constitute a waiver of the right to review and an acceptance of the hearing panel decision, which shall become effective pending final decision by the Board as provided in the case of a waiver of a hearing.

2. Appellate Review Prerequisites. Within ten days after receipt of a request for a permitted review, the board shall schedule and arrange for a review hearing, including oral argument, if requested. The Administrator shall send notice to the practitioner of the date, time and place of the hearing at least seven days prior thereto. The hearing date shall be not less than ten nor more than 45 days from receipt of the request; provided, a hearing for a practitioner who is under suspension then in effect shall beheld as soon as arrangements for it may reasonably be made, but not later than 15 days from the date of receipt of the request. The review hearing shall be conducted by the Board or by an appellate review committee consisting of at least four Board members. The time for the hearing may be postponed only upon mutual agreement of the practitioner and the review body. A person shall be disqualified from serving on a hearing committee if he has participated in initiating or investigating the matter at issue if he is in direct economic competition with the practitioner involved, but not merely because he served as a member of the hearing panel and participated in the prior hearing.

APPELLATE REVIEW PROCEDURE

1. Appellate Review Proceedings. The proceedings of the review body shall be in the nature of an appellate review based on the record of the hearing before the hearing panel, the hearing panel's report and subsequent actions. The practitioner seeking review shall have access to the record and report of the prior hearing. He may, at least four days prior to the date of the review hearing, submit a written statement detailing the findings of fact, conclusions and procedural matters raised at any state in the hearing, submit a written statement detailing the findings of fact, conclusions and procedural matters with which he disagrees and his reasons for disagreement. The written statement may cover any matters raised at any stage in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review body through the Administrator. A similar statement or a reply may be submitted by the Staff, and if submitted, the Administrator shall provide a copy thereof to the practitioner at least three days prior to the date of the review hearing.

2. Appellate Review Hearing. The members of the appellate review body shall designate one of the members as chairman. The chairman of the appellate review body shall act as presiding officer. He shall determine the order of procedure for review, make required rulings and maintain decorum. If oral argument has been requested by the practitioner, his personal presence shall be required or oral argument shall be deemed to have been waived. If he is present, he shall be permitted to speak and may be required to answer questions asked by any member of the review body. New or additional matters or evidence not raised or presented at the original hearing or in the hearing report may be introduced at the review hearing only in the discretion of the review body. The review body shall have all authority granted to a hearing committee and such further authority as may be necessary to discharge its responsibilities. Upon conclusion of the oral statements, the review hearing shall be closed. The review body shall then at a time convenient to itself, privately conduct its deliberations, reach a decision and adjourn.

3. Decision on Review. If the review hearing is conducted by the entire Board, the Board may affirm, modify or reverse the recommendation of the hearing panel. If it appears that the decision of the Board is contrary to the hearing panel recommendation, the Board shall refer the matter to the hearing panel for further review and recommendation to be returned within ten days. If the review hearing is conducted by a review committee of the Board, the Committee shall within ten days of adjournment of the review hearing, recommend that the Board affirm, modify or reverse the recommendation of the hearing panel. The appellate review process shall be deemed completed when all of the foregoing procedural steps have been completed or waived.

4. Final Decision. Within ten days after the conclusion of the appellate review process (or within 30 days if the Board decision appears to be contrary to the recommendation of the hearing panel), the Board shall render its final decision in the matter in writing. If the Board decision is in accord with the hearing panel recommendation, it shall become immediately effective and final, and the Board shall direct the Administrator to send notice to the practitioner, the hearing panel and the Executive Committee. If the Board action is contrary to or has the effect of changing the hearing panel's last recommendation, the Board shall refer the matter to a joint conference of equal numbers of Staff and Board members. Within 14 days after referral, the joint conference shall convene and submit a recommendation to the Board. The Board shall than again act on the matter, and the Board decision shall be immediately effective and final, and the Board shall send notice thereof to the practitioner, the hearing panel and the Executive Committee.

MISCELLANEOUS

1. Number of Hearings and Reviews. No practitioner shall be entitled as a right to more than one evidentiary hearing and one appellate review with respect to an adverse recommendation or action. At the discretion of the hearing panel or the Board or its review committee, adverse recommendations on more than one matter may be consolidated and considered together or separately.

2. Release. By requesting a hearing or appellate review, a practitioner confirms and agrees to be bound by the provisions of Article XIII of the Bylaws (Privileges and Immunities).

3. Notices. All notices, requests, demands, reports, written statements and other communications required or permitted to be given to a practitioner in the Fair hearing Plan shall be deemed to have been duly given if in writing and delivered personally or deposited in the United States certified or registered mail, postpaid, to the address of the applicant or appointee on his application or to his last known address.

FAIR HEARING PLAN

ARTICLE II

Allied Health Professionals

GENERAL

1. Purpose. This document sets forth the Allied Health Professionals' Fair Hearing Plan for the Hospital. The provisions of this document are subject to the provisions of the Medical Staff Bylaws. The terms defined in the Medical Staff Bylaws shall have the same meaning.

2. Adoption and Amendments. This document may be adopted, amended, revised, modified, restated, and repealed in the manner set for thin the Bylaws.

3. Distribution. A copy of this document and all amendments and modifications shall be maintained in the Staff records, the records of each committee, and the records of each department.

4. Limitations. This plan is not designed for review of employer-employee or supervisor-employee issues should be addressed by employer hiring and supervision practices (see Article V, paragraph 3). This plan addresses medical credentialing and performance issues after the allied health professional has been granted initial credentials.

INITIATION OF HEARING

1. Adverse Action.

   A. Adverse recommendations or actions on the following shall entitle the practitioner affected thereby to a hearing:

      (1) Denial of reappointment;

      (2) Involuntary reduction of clinical privileges;

      (3) Suspension of clinical privileges; or

      (4) Revocation of clinical privileges.

   B. Adverse recommendations or actions on the following shall not entitle the allied health professional affected thereby to a hearing:

      (5) Failure to maintain at least one sponsoring physician;

      (6) Termination of employer-employee relationship with physician; or

      (7) Termination of employer-employee relationship with the hospital (with or without a contract).

2. When Deemed Adverse. A recommendation or action shall be deemed adverse only when it has been:

   A. Recommended by the Executive Committee;

   B. Taken by the Board; or

   C. In the case of summary suspension, taken by the anyone entitled to summarily suspend privileges, except that if a summary suspension is in effect for 14 days or less, during which an investigation is conducted, such suspension, of itself, shall not entitle the practitioner affected thereby to a hearing. The issuance of a warning, a request to appear before a committee, a letter of admonition, a letter of reprimand and the denial termination or reduction of temporary privileges shall not constitute adverse action.

3. Notice of Action. An allied health professional shall be promptly given written notice of an adverse recommendation or action against him. The notice of adverse recommendation or action shall state:

A. That an adverse recommendation or action has been made or is proposed to be made or taken against him;

B. The reasons for the action or recommendation;

C. That he has a right to request a hearing on the action or recommendation in accordance with the bylaws, at anytime within 15 days after receipt of the notice;

D. That failure to request a hearing shall constitute a waiver of a right to a hearing;

E. That if a hearing is requested on a timely basis, he will be given further notice stating the time, place, and date expected to testify at the hearing on behalf of the hospital or the professional review body.

F. Also, the notice of adverse action or recommendation shall state that a record will be made of the proceedings, copies of which may be obtained by the allied health professional upon payment of any reasonable charges associated with the preparation thereof.

G. In addition, the notice of adverse action or recommendation shall state that the allied health professional has the right to cross-examine any witnesses; present evidence determined to be relevant by the hearing officer or panel, regardless of its admissibility in a court of law; the right to submit a written statement at the close of the hearing; and upon completion of the hearing, to receive the written recommendation of the hearing officer or panel, including a statement of the basis for the recommendations, and to receive a written decision of the hospital, including a statement of the basis for the decision.

4. Request and Waiver. An allied health professional shall have 15 days following his receipt of notice of adverse action to request a hearing. The request shall be given in writing to the CEO or by personal delivery or by certified or registered mail and shall be deemed given when received by the CEO. Failure to a timely request of a hearing shall constitute a waiver of the hearing. In case of a waiver of an adverse recommendation by the Executive Committee, the recommendation shall become effective pending final decision by the Board. The Board shall consider the recommendation at its next regular meeting, and its decision shall be final.

HEARING PROCEDURE

1. Notice and Time for Hearing. Within 7 days after receipt of a request for a permitted hearing, the Medical Executive Committee shall schedule and arrange for a hearing. Administration shall send notice to the allied health professional of the place, time, and date of the hearing, at least 7 days prior thereto. The hearing date shall be not less than 15 nor more than 30 days from receipt of the request, but in any event, not less than 15 days after the date of the notice of the adverse actions initially sent. The notice shall contain a list of the specific or representative patient records in question or other reasons or subject matter forming the basis for the adverse recommendation or action. Also, the notice shall contain a list of the witnesses, if any, expected to testify at the hearing on behalf of the Medical Staff and shall require that a list of witnesses expected to testify on behalf of the allied health professional be submitted within 10 days. The notice may state that the Medical Staff or the hospital, as the case may be, reserves the right to amend the lists of documents, information, and witnesses, and if needed, prompt notice of any amendment will be given to the allied health professional. Request for postponement of a hearing shall be permitted only upon mutual agreement of the allied health professional and the hearing panel.

2. Hearing Officer or Panel. The hearing shall be held before a hearing officer or panel of individuals who are appointed by the Medical Executive Committee who have no competitive, economic, or supervisor interests with the allied health professional involved. The Medical Executive Committee shall determine whether to utilize a hearing officer or a hearing panel. If a hearing panel is utilized, at least a majority of the members of the panel must be present during the hearing. Also present shall be the chairman of the department in which the allied health professional is assigned, or in his absence or disqualification, another active member of such department, appointed by the chief of staff. A person shall be disqualified from serving as a hearing officer on a hearing panel if any of the conditions in the first sentence of the paragraph apply.

3. Conduct of Hearing. The personal presence of the allied health professional who requested the hearing shall be required. His failure to appear without good cause shall constitute a waiver of his right to a hearing and an acceptance of the adverse recommendation or action, which shall become effective immediately. The hearing officer shall maintain decorum and ensure that all participants have an opportunity to present relevant oral and documentary evidence. He shall determine the order of procedure and make rulings on issues and matters. The hearing panel or officer shall then, at a time convenient to itself, privately conduct its deliberations, reach a decision and adjourn. Within 14 days after adjournment, the hearing panel or officer shall prepare a written report if its findings and recommendations, including a statement of the basis for the recommendations and forward it to the Medical Executive Committee. If the Medical Executive Committee disagrees with the adverse recommendation, the matter is ended. If the Medical Executive Committee approves the adverse recommendation, it is submitted to the Board, whose decision is final.

4. Miscellaneous. No allied health professional shall be entitled as a right to more than one evidentiary hearing with respect to an adverse recommendation or action. At the discretion of the hearing panel or the Board, adverse recommendations on more than one matter may be consolidated and considered together or separately. By requesting a hearing, an allied health professional confirms and agrees to be bound by the provisions of Article XIII of the Bylaws (Privileges and Immunities). All notices, requests, demands, reports, written statements, and other communications required or permitted to be given to an allied health professional in the Fair Hearing Plan shall be deemed to have been duly given if in writing and delivered personally or deposited in the United States certified or registered mail, postpaid, to the address of the applicant on his application or to his last known address.

MEDICAL STAFF RULES AND REGULATIONS – APPENDIX B

GENERAL

1. This document sets forth the Rules and Regulations of the Medical Staff and is subject to the provisions of the Medical Staff Bylaws. The terms defined in the Medical Staff Bylaws shall have the same meanings herein.

2. These Rules and Regulations may be adopted, amended, revised, modified, restated and repealed in the manner set forth in the bylaws.

ADMISSION AND DISCHARGE

1. All practitioners with authority to admit patients will be governed by the official admitting policy of the Hospital.

2. Patients may be admitted and discharged only on order of the attending physician. Patients should not be admitted as a matter of convenience while only undergoing tests or therapy that could be obtained on an outpatient basis. If the patient admission was initiated from a private office, the admitting physician must have seen the patient immediately prior to admission and have signed the admission orders.

3. Patients shall be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds:

   A. Emergency;

   B. Urgent; or

   C. Elective.

4. Practitioners shall use their best efforts to make necessary arrangements in order for all elective admissions to be admitted to the Hospital during normal business hours.

5. No patient will be admitted to the Hospital until a provisional diagnosis has been recorded.

6. Prior to admitting a patient, the practitioner or his office staff shall, when possible, first contact the admitting office or, if closed, the nursing service supervisor to ascertain if there is a bed available.

7. Practitioners must be able to justify emergency admissions based on criteria developed by the Staff. The history and physical must clearly justify the patient being admitted on an emergency basis, and all findings must be recorded on the patient's medical record as soon as possible after admission.

8. A patient to be admitted on an emergency basis will be given the opportunity to select a member of the active or provisional staff to be responsible for the patient while in the Hospital. If a dentist or podiatrist is selected by the patient, a physician shall be selected to assume the medical responsibility for the patient. Where no selection is made or where the selected practitioner does not assume responsibility for care of the patient for some reason, the patient shall be assigned to the on-call physician.

9. A patient will not be transferred between units within the Hospital without the approval of attending physician. The order of priority for patient transfers shall be as follows:

   A. Emergency department to appropriate nursing unit;

   B. From general care unit to acute health care;

   C. From intensive care unit to acute health care;

   D. From temporary placement in an inappropriate nursing unit or clinical service to the appropriate service or nursing unit; and

   E. From obstetric care unit to general care unit.

10. Admissions and discharges to special care units shall be in accordance with established criteria. Exceptions shall be approved by the unit or service medical director.

11. Patients may be discharged from the Hospital on the order of the patient's attending physician. If a patient leaves the Hospital against the advice of the attending physician or without proper discharge, a notation shall be made in the patient's medical record as well as attempts made to obtain signed AMA form.

12. In the event of a Hospital patient death, the deceased will be pronounced dead by the attending physician or his designee in accordance with Florida Statutes within a reasonable time. The attending physician will complete and sign the death certificate. The body will not be released until an entry has been made and signed in the medical record of the deceased by the attending physician or designee. Policies with respect to release of deceased shall conform to local law.

13. Pediatricians will admit patients under the age of 16. Unattached patients age 16 years and older requiring medical admission will be admitted by the appropriate physicians other than pediatricians. This would not preclude specialists from admitting patients under the age of 16 when appropriate.

EMERGENCY DEPARTMENT SERVICES

1. Members of the Staff shall accept responsibility for emergency care in accordance with emergency department policies and procedures.

2. The physician director of the emergency department shall have the overall responsibility for emergency department care, subject to the authority of the Board.

3. Emergency department policies and procedures shall be approved by the director of the emergency department, and the Executive Committee of the staff and the Board.

4. At least one emergency department physician shall be in the Hospital and immediately available for rendering emergency patient care 24 hours per day, 7 days per week.

5. The patient's private practitioner or the on-call practitioner shall be called in accordance with emergency department policies and procedures.

6. If a patient needs to be admitted to the Hospital as an inpatient, either for observation or for further treatment, the patient shall be admitted in the name of the patient's practitioner or the practitioner on-call. If in the judgment of the emergency department physician the patient's condition requires continuing attention, the emergency department physician shall continue to accept responsibility for the patient until the assigned practitioner assumes responsibility for the patient. The assigned practitioner shall come to the Hospital as promptly as possible if requested by the emergency department physician.

7. All patients over 20 weeks gestation, unless otherwise specified by the attending physician, who present to the Emergency Department with an obstetric complaint, will go directly to Labor and Delivery for an evaluation. In the absence of the physician or appropriately credentialed allied health professional, the screening assessment information may be collected by non-physician personnel determined to be qualified according to established OB-GYN Department specific approved policies and protocols. In addition to the Department of OB-GYN approval, the policies and protocols will be reviewed and approved by the Medical Executive Committee and the Board of Trustees. The disposition of the patient’s admission status will be determined by the assigned practitioner. The assigned practitioner shall come to the Hospital as promptly as possible if indicated by the screening.

8. Emergency department physicians, nurse practitioners, and physician assistants shall maintain current certification in advanced cardiac life support. Allied health practitioners employed by the Emergency Room physicians, who are properly credentialed, may perform screening exams.

9. An appropriate emergency department record or log shall be kept listing every person who presents himself or is brought to the emergency department for treatment or care and a notation concerning treatment or transfer. An appropriate emergency department medical record shall be kept for every patient assessed and/or treated shall be included in the patient's previous inpatient medical record, if such exists. The emergency service medical record shall include: adequate patient identification; information concerning the time of patient's arrival and by whom transported; pertinent history of the

injury or illness, including details relative to first aid or emergency care given the patient prior to his arrival at the Hospital and history of allergies; description of significant clinical, laboratory and x-ray findings; diagnosis, including condition of patient; treatment given and plans for management; condition of the patient on discharge or transfer; and final disposition, including instructions given to the patient or his family, relative to necessary follow-up care.

10. The patient's medical record must be signed by all responsible practitioners rendering care to the patient.

11. A copy of the emergency department medical record shall accompany patients being admitted as inpatients.

12. The director of the emergency department shall coordinate the review of emergency department records with the responsible medical staff committee.

13. Except in cases where transfer to surgery is contraindicated, general anesthesia shall not be administered in the emergency treatment area.

14. The emergency department physician shall arrange for an interpretation of x-rays by a radiologist and comparison of initial and final x-ray interpretations. In cases where an x-ray interpretation of the radiologist is different from that initially made by the emergency department physician, the radiologist shall notify the emergency department physician and/or the patient's private physician as soon as possible, and copies of the radiologist's report shall be made available to the emergency department physician and the patient's private physician.

15. Patients with conditions whose definitive care is not within the scope of services provided by the Hospital shall be referred to an appropriate facility when, in the judgment of the attending physician, the patient's condition permits such a transfer. No patient shall be arbitrarily transferred, and inquiry shall be made as to acceptance of the patient by the receiving hospital and physician. A copy of pertinent medical records shall accompany the transfer. The Hospital's Transfer Policy for patient transfers to other facilities shall be followed.

16. The director of the emergency department shall make certain that emergency department procedures are properly coordinated with the Hospital's Emergency Preparedness Plan, especially as they pertain to the care of mass casualties.

17. "55 Rule."

    A. Medical staff members who have attained the age of 55 or more, and have served as active staff members at Gulf Coast Medical Center for 5 or more years may, at their discretion, retire from Emergency Room call for their specialty. This does not exclude them from seeing or providing coverage for their private patients who may present to the Emergency Room.

    B. Upon reaching age 54, any medical staff member who intends to exercise the option to retire from Emergency Room call at age 55 should provide, in writing, a minimum notice of 12 months to the Executive Committee.

MEDICAL RECORDS AND ORDERS

1. The attending physician will be responsible for the preparation and completion of a legible medical record. He is responsible only for those parts over which he has control. Its content shall be pertinent and current for the patient and shall include:

    A. Identification data;

    B. Chief complaint;

    C. Medical history;

    D. Family history and history of the present illness;

    E. Physical examination;

F. Diagnostic and therapeutic orders;

G. Appropriate informed consents;

H. Clinical observations, including results of therapy, progress notes, consultations, comments on laboratory and x-ray and other reports;

I. Provisional and final diagnosis;

J. Medical or surgical treatment;

K. Pathologic findings;

L. Reports of procedures, tests and results, including operative reports;

M. Discharge summary, condition on discharge and instructions given for further care, such as medications, diet or limitations of activity; and

N. Autopsy report, if one is performed.

2. A complete admission history and physical examination on each patient must be written or dictated within 24 hours of admission. This report should include all pertinent findings resulting from an assessment of all systems of the body. If a complete history has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a reasonably durable, legible copy of such reports may be used in the patient's Hospital medical record in lieu of the admission history and report of the physical examination, provided the reports were recorded by an appointee of the Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must also be recorded. Short forms are available for invasive procedures. If the patient stays over 48 hours, a full history and physical must be dictated within 72 hours of admission. A history and physical are required on

   A. All surgical procedures;

   B. Invasive procedures that may require a 23-hour admission/observation; and

   C. Other invasive procedures at the discretion of the physician.

3. A short form history and physical may be used on any outpatient or any admission under 48 hours. After 48 hours, a formal history and physical is required.

4. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes shall be written daily on all patients by the admitting physician or his physician designee.

5. All orders, the history and physical examination, progress notes, and pre-operative notes recorded by non-physicians shall be countersigned by the attending physician within 24 hours.

6. All clinical entries and summaries in the patient's medical record shall be accurately dated and authenticated by the responsible practitioner.

7. Symbols and abbreviations within the Hospital abbreviation list may be used only when they have been approved by the Staff.

8. Licensed clinical staff may write in the appropriate areas of the patient’s medical record.

9. The attending physician shall complete the medical record at the time of the patient's discharge, including progress notes, final diagnosis and discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the medical

record will be available in the Medical Records Department. If the discharge summary cannot be dictated at the time of discharge, a final progress note must be written in the medical record.

10. A history and physical examination must be recorded on the patient's medical record before an operation or any potentially hazardous procedure is performed, unless delaying the procedure would be detrimental to the patient, in which case, a brief note describing the history, appropriate physical findings and preoperative diagnosis will suffice.

11. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Staff Executive Committee or other appropriate medical staff committee. Permanently filing incomplete medical records will be in accordance with Hospital Policy.

12. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients.

13. A discharge summary shall be written or dictated on all medical records of patients hospitalized over 48 hours. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be signed by the responsible practitioner. Physicians should include their physician ID number when signing patient records.

14. A practitioner will be considered delinquent in completion of his medical records if the records are not completed, written, or dictated within 28 days of the patient's discharge. A written notice of delinquency will be issued to those practitioners affected on a weekly basis.

    A. Any physician with incomplete records greater than 21 days will receive a call from Medical Records personnel advising them to complete the records prior to the following week to avoid delinquency.

    B. At 28 days from the date of discharge, charts are considered delinquent, and the physician is placed on the delinquency list and fines are assessed at the rate of one dollar per record over 28 days delinquent.

    C. At 35 days, notification shall be made by the C.E.O., reminding the physician of possible suspension.

    D. At 42 days, notification shall be made by the Medical Executive Committee, reminding the physician of possible suspension.

    E. Any physicians with records that are still delinquent at 49 days shall be sent a certified letter, or a hand-delivered letter with a signed receipt of delivery, stating that their ability to admit, consult, or care for patients has been suspended. This suspension does not affect the physician's ability to continue to treat patients in the hospital at the time of the suspension. The automatic suspension will be effective upon the physician's receipt of notification and may continue until all medical records are completed, or, after 21 additional days, his privileges will be revoked.

    F. The Admitting Office shall be notified of this action by C.E.O., as well as the Chairman of the physician's department. Reinstatement of privileges will be automatic upon the completion of records and payment of fine, and the Director of Medical Records shall inform the Admitting Office.

    G. The Medical Records Department will be responsible for analyzing medical records for the purpose of administering this rule.

15. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive such information. No one other than authorized persons shall have access to or information from the medical records without the written permission of the patient, in which case the written permission shall be attached to the record. However, information may be obtained from medical records in compliance with state law. Medical information for the purpose of establishing the patient's claim for hospitalization insurance or other third party payment or reimbursement will be provided only as a matter of routine to the insurance company or payor after the consent of the patient has been obtained (unless consent is not required) and will be provided only on the currently acceptable insurance or payor form.

16. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken or removed from the Hospital without the permission of the Administrator. All original x-ray films are the property of the Hospital and shall not be removed. In any case of readmission of a patient, all previous records shall be available for the use of the attending physician. This will apply whether the patient is attended by the same practitioner or by another.

17. Access to medical records of patients will be afforded to members of the Staff to the extent permitted by law or by legally effective patient consents.

18. All orders for treatment must be in writing. An order will be considered to be in writing if dictated to authorized personnel and signed by the ordering practitioner. Authorized personnel include any registered nurse, licensed practical nurse, registered respiratory therapist, pharmacist, registered physical therapist, or registered dietician to the extent it is within the scope of his license. Orders dictated by telephone shall be documented by the person to whom dictated with the name of the practitioner and then signed by the person to whom dictated. Within 24 hours, the ordering practitioner shall sign the orders. Orders for medication must designate drug, dosage, and method and frequency of administration. PRN medications must include indications for administration.

19. Preprinted orders may be formulated by individual members of the active staff and placed on file at the Hospital. These orders must be recorded on the patient's medical record and signed by the attending physician. Preprinted orders shall not, however, replace or cancel those written for the specific patient. Preprinted orders shall be reviewed at least annually and revised as necessary.

20. All orders will be canceled for a patient when transferred to or from a critical care unit and surgical units.

21. The Query Form – The documentation of the inpatient coder’s query to the physician with the physician’s response will be included as a permanent part of the medical record unless an addendum is included to resolve the diagnosis in question.

22. The use of signature stamps and electronic signatures are permitted in the medical record. The individual using the signature will sign a form stating that he/she will:

    A. be the only one using the stamp,
    B. not knowingly reveal their personal identifier (password) to anyone,
    C. nor allow another to knowingly use it.

    The signed statements are kept in the Medical Record Department. If signature stamps or electronic signatures are used improperly, sanctions will be imposed.

23. Written, signed informed consent shall be obtained prior to an invasive procedure, except in those situations in which the patient’s life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in whom an informed consent cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient’s medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits. Discussion of the informed consent should comply with Florida Statutes.

24. The practitioner or AHP (within the limits of his privileges) will dictate or write a procedure report in the patient’s medial record for any surgical or invasive procedure he performs. The note will include, at a minimum, a pre-procedure diagnosis or indication(s) for the procedure, a post-procedure diagnosis, a detailed description of the techniques of the procedure, and a description of the findings. Procedure reports will be written or dictated immediately following the procedure, when possible, and dictated reports will be signed by the responsible practitioner promptly and made part of the patient’s current medical record.

25. Practitioners may sign orders, progress notes, and other items in the medical records for other practitioners in their coverage group with the following exceptions: history and physicals, procedure notes, operative reports, and consults.

SURGICAL CARE

1. Except in emergencies, a history and physical examination, the pre-operative diagnosis, appropriate consents, required laboratory and radiology reports, and consultation, when requested, must be recorded on the patient's medical records prior to any surgical procedure. In the case of an emergency, where any or all of the above entries have not been made in the medical record, the operating surgeon shall state in writing that a delay would be detrimental to the patient (and shall make a comprehensive note in the medical record indicating the patient's condition prior to induction of anesthesia and the start of surgery) and that the patient's condition is deemed to be satisfactory for the planned surgery. In all other cases the responsible nurse shall notify the operating surgeon, preferably no later than the night before surgery is scheduled, and preparation for surgery including premedication shall not be performed until proper entries are recorded in the patient's medical record. If this delay causes a change to be made in the surgery schedule, the operation shall be rescheduled to the next available time.

2. Surgeons shall be in the operating room and ready to commence surgery at the time scheduled.

3. Patients who are admitted to the Hospital more than seven days prior to major surgery shall have a new physical examination recorded. It shall include at least the heart, lungs and other vital signs by the attending physician, the operating surgeon, or the anesthesiologist. Proper notes shall be made in the progress notes as to the findings. The operating surgeon shall be responsible for such physical examinations having been completed prior to surgery.

4. The pre-operative guidelines for Anesthesia will be established by the Department of Surgery.

5. If, in the opinion of the operating surgeon and/or the chairman of the Department of Surgery, there is in any surgical procedure an unusual hazard to life, there shall be present and scrubbed, as first assistant, a qualified surgeon.

6. The rules for the scheduling of elective or non-emergency surgery will be as follows:

    A. The schedule is available for posting of cases at all times.

    B. The following information is required in order to post a case:

        (1) The patient's full name;

        (2) Date of Birth;

        (3) Planned Surgical Procedure;

        (4) Diagnosis;

        (5) Status (OP, IP, 23 hour, etc);

        (6) Operating Surgeon; and

        (7) Time and name of person posting the case.

    C. The order of cases will be based on the time of the cases posted, available operating room personnel, room cleaning, etc., as determined by the operating room supervisor.

    D. If cleared in advance with the operating room supervisor, cases may be posted at a specified time for justifiable reason, or if they do not interfere with the normal operating room schedule.

7. A pre-anesthesia evaluation shall be performed by an individual qualified to administer anesthesia within 48 hours prior to surgery and noted in the patient’s medical record prior to the patient’s transfer to the operating area and before pre-operative medication has been administered. This note shall indicate a choice of anesthesia, the surgical or obstetrical procedure anticipated, and the patient's prior anesthetic history. When the pre-anesthesia evaluation is not performed by an anesthesiologist, there will be a written documentation that the anesthesiologist has reviewed and concurs with the pre-anesthesia evaluation prior to the administration of anesthesia.

8. A post-anesthesia evaluation shall be performed by an individual qualified to administer anesthesia within 48 hours for inpatients and according to Hospital policy for outpatients and noted on the patient’s

chart. This note should include at least a description of the presence or absence of anesthesia-related complications.

9. Each anesthesia entry shall be dated, signed and authenticated by the responsible practitioner.

10. The anesthesiologist or anesthetist shall maintain a complete anesthesia record which includes evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

11. The attending surgeon shall ensure that tissues removed in an operation, as required by the tissue review function, shall be sent to the Hospital pathologist, who shall make such examination as he may consider necessary to arrive at a pathological diagnosis. His report shall be made a part of the patient's medical record. Each specimen shall be accompanied by necessary information including the preoperative diagnosis, description of tissue and brief pertinent clinical data which the surgeon will complete or cause to be completed.

12. The attending surgeon shall complete or cause to be completed the proper form available to describe each operation. The report shall be made a part of the patient's medical record. Operative reports shall include a detailed account of the findings at surgery, as well as the details of the surgical technique. Operative reports shall be written or dictated immediately following surgery when possible, and the report shall be promptly signed by the surgeon and made a part of the patient's current medical record.

13. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chairman of the Department of Surgery.

14. A staff appointee who is classified as a preceptor for specified surgery privileges must have present his qualified assistant for these specified surgery procedures.

15. When an operating/anesthesia team consists entirely of non-physicians (i.e. dentists with nurse anesthetist), there shall be a previously designated physician immediately available in the operating room area in case of emergency. The physician must have submitted the necessary form attesting to his willingness to assume such responsibility.

OBSTETRICAL CARE

1. The current obstetrical records shall include a complete prenatal record. All obstetrical medical records shall have complete prenatal histories, physical examinations and discharge summary. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital and shall be up-to-date, and shall include findings since the time of the last visit.

2. Informed consent for the delivery shall be obtained on the patient's arrival to labor area.

3. Patients having Cesarean sections or postpartum tubal ligations shall have an updated history and physical examination. A progress note on important or new physical findings since her last physical examination on the pregnancy record shall suffice.

4. Sterilization for the sole purpose of sterilization for either male or female patients may be done at the discretion of the attending physician with the informed consent of the patient being sterilized.

5. Oxytocic drugs shall be used in the following manner:

    A. Intravenous oxytocic drugs shall be initiated only by order of attending physician who has personally evaluated patient immediately prior to such administration;

    B. Intravenous oxytocin for induction of labor shall be administered by piggyback;

    C. Simultaneous elective inductions shall be scheduled based on the consideration of existing staffing capabilities. Oxytocin challenge tests will be considered in a similar manner. Elective inductions may be scheduled by calling the labor and delivery nurse; and

    D. The reason for induction labor shall be stated in the history or progress notes.

6. All previous orders are canceled after Cesarean section or postpartum tubal ligation.

7. Diagnostic dilation and curettage in the childbearing age group will not be performed unless the medical record reflects a pre-operative negative pregnancy test.

8. All patients who are going to undergo caudal, spinal, saddle block or epidural anesthesia should have an I.V. started prior to the administration of the anesthesia.

9. Interruption of pregnancies during the first l2 weeks of gestation may be performed in accordance with the law, applicable policies of the Board, and in accordance with the guidelines developed by the Department of Obstetrics and Gynecology. The Department of Obstetrics and Gynecology has adopted the policy of following guidelines set forth in the most current issue of the "Standards for Obstetric-Gynecologic Services," published by the American College of Obstetricians and Gynecologists.

NEWBORN CARE

1. All newborn orders must be itemized, including orders for formula and care of the newborn, and signed by the physician.

2. A physical examination shall be recorded in the medical record of all newborns within 24 hours of delivery.

3. PKU tests shall be done on all newborns prior to discharge if the newborn has been on milk for 48 hours. If this is not the case, the mother shall be given instructions as to where and when this procedure is to be done.

4. If a Family Practice Physician wants normal newborn privileges, then he/she will take normal newborn call.

5. If a Physician is boarded in both Pediatrics and Internal Medicine, then he/she will share ER call 50/50 for each department.

6. If a Family Practice Physician wants Pediatric privileges and has at least 10 admissions per year, then he/she will take one-half call.

ICU CARE

1. Only a physician can make the decision to admit or transfer a patient in and out of the ICU.

2. The attending physician should see ICU patients at a minimum of once a day, and initially within a reasonable period of time. Allied Health Practitioners may function as additional “eyes and ears” for the physician, but they should not act independently.

3. Allied Health Practitioners should not give verbal orders or write orders in the critical care setting unless in consultation with the attending physician, who should document agreement of the order in the progress notes.

TELEMEDICINE

1. Radiology:

   A. The following studies may be sent via telemedicine equipment link after normal business hours:

      (1) Ultrasound;

      (2) Nuclear Medicine;

      (3) CT scan;

      (4) MRI; and

      (5) Plain Radiograph.

B. A member of the Department of Radiology will perform the final interpretation of these studies the following morning.

CANCER COMMITTEE

The medical staff supports the hospital Cancer Committee policies approved by the American College of Surgeons and will actively participate in its mission.

EMERGENCY PREPAREDNESS PLAN

There shall be a plan for the case of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be reviewed and approved by the Staff and the Board and rehearsed twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The medical staff's role in the management of care areas is addressed in the Hospital's Emergency Preparedness Plan.

DRUGS AND MEDICATION

1. All medications brought into the Hospital by a patient will be sent home, if possible, otherwise they will be properly identified pursuant to Pharmacy policy.

2. All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital formulary Service or AMA Drug Evaluations. Drugs of bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principal involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

3. All antibiotics and narcotic medications, hypnotics and steroids, sedatives, oxytocics will carry automatic stop orders as stated in Pharmacy Policies and Procedures. If the practitioner desires to continue these medications, he must reorder them at the end of this period. The attending physician or his designee shall be notified by the responsible nurse when drugs are due for an automatic stop order.

4. Anticoagulants should only be written for a twenty-four-(24) hour period. Unless otherwise specified, they should be stopped automatically at the end of forty-eight (48) hours.

5. Certain medications may be administered only by a physician or under his direct supervision when given by the I.V. push method. These medications include:

   A. Those medications for which no "FDA Approved" indication for direct I.V. administration, i.e.: I.V. push, is stated in the official package insert unless such medication has been specifically exempted from this restriction by the Executive Committee;

   B. Those medications having "FDA Approved" indication for direct I.V. push administration but which have been restricted from such administration by the Executive Committee. A list of the latter drugs shall be maintained in the policy manuals of nursing services and the department of pharmacy.

6. Only those individuals authorized by both State practice acts and Hospital policy should administer IV push medications under any circumstances.

GENERAL CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the Hospital, shall be obtained at the time of admission. The admitting office shall notify the attending physician whenever such consent has not been obtained. The attending physician shall make an entry in the medical record explaining the reason the consent was not obtainable. Blood administration consent will be in accordance with Hospital Policy.

2. Each member of the Medical Staff, as well every Practitioner or Allied Health Professional with clinical privileges and each Practitioner with temporary privileges (collectively herein referred to as the "Provider" in this paragraph), shall be part of the Organized Health Care Arrangement with the Hospital (unless they opt out), which is defined in 45 C.F .R. §164.501 , (which is part of what is commonly known as the HIPAA Privacy Regulations) as a clinically-integrated care setting in which individuals

typically receive health care from more than one healthcare provider. This arrangement allows the Hospital to share information with the Provider and the Provider's office for purposes of the Provider's payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Practitioners or Allied Health Professionals with clinical privileges, and Practitioners with temporary privileges.

3. All requests for radiology and nuclear medicine service must include information from the requesting practitioner justifying the need for the examination requested.

4. Radiology procedures will not be performed on women capable of bearing children if it is more than ten days following the first day of the monthly menstrual cycle, unless a pregnancy test is performed.

5. All members of the Staff shall be actively interested in securing autopsies when appropriate. No autopsy may be performed without the written consent of the responsible party in compliance with State law and notification of the attending physician. All autopsies shall be performed under the direction of the Hospital pathologist.

6. The criteria for consideration of autopsy are:

   A. Deaths in which an autopsy may help explain unknown and unanticipated medical complications.

   B. Deaths in which the cause is not known with reasonable certainty on clinical grounds.

   C. Cases in which an autopsy may help allay concerns of the family and provide reassurance to them regarding the same.

7. The following deaths occurring in the Hospital are under the jurisdiction of the Medical Examiner pursuant to F.S. 406.11:

   A. Deaths known or suspected to have resulted from environmental or occupational hazards.

   B. Unexpected or unexplained deaths occurring during any dental, medical or surgical diagnostic and/or therapeutic procedure.

   C. Deaths occurring in the emergency room prior to hospitalization.

   D. Deaths in which the patient sustained or apparently sustained injury while hospitalized.

   E. Deaths occurring in a patient who was hospitalized due to attempted suicide, attempted homicide or accident even though the immediate cause may not be related to the reason for admission.

8. A physician member of the Staff will be responsible for the medical care of each patient in the Hospital. The attending physician will be responsible for the treatment and the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient, if appropriate, to any referring practitioner. Whenever these responsibilities are transferred to another practitioner, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. A progress note summarizing the patient's condition and treatment shall be made, and the practitioner transferring his responsibility shall personally notify the other practitioner to ensure the acceptance of that responsibility is clearly understood. The patient will be assigned to the service concerned in the treatment which necessitated admission. In a case where there is no emergency, but a patient requiring admission has no practitioner, he shall be assigned to the practitioner on-call for the service to which the illness of the patient indicates assignment, provided the practitioner agrees to accept the patient.

9. Each member of the Staff shall name another member of the Staff with similar privileges as an alternate to be called to attend his patients in an emergency when the staff member is not available or until the staff member can be present. In any case, when the appointee cannot be reached or is unavailable, the designated alternate physician shall be called. In case the alternate is not available, the Administrator or the Chief of Staff will have the authority to call the on-call practitioner or any other member of the Staff with similar privileges to attend the patient.

10. Restraints will be ordered, applied, and monitored in accordance with Hospital policy.

11. Each member of the staff will abide by the guidelines set forth in the Hospital policy concerning advance directives, healthcare surrogates, and withholding or withdrawing life prolonging procedures.

NON-PHYSICIANS

1. A patient admitted for dental care is a dual responsibility of the dentist and physician member of the Staff.

   A. Dentist's responsibilities:

      (1) A detailed dental history justifying hospital admission;

      (2) detailed description of the examination of the oral cavity and a pre-operative diagnosis;

      (3) A complete operative report, describing the findings and techniques;

      (4) In cases of extraction of teeth and fragments removed, all tissue including teeth and fragments shall be sent to the hospital pathologist for examination;

      (5) The dentist is totally responsible for the oral or dental care;

      (6) Progress notes as are pertinent to the oral condition; and

      (7) Discharge summary.

   B. Physician's responsibilities:

      (1) Medical history pertinent to the patient's general health;

      (2) Physical examination to determine the patient's condition prior to anesthesia and surgery;

      (3) Supervision of the patient's general health status while hospitalized;

      (4) Physician is not responsible for dental care or consequences thereof; and

      (5) Availability during performance of a surgical procedure.

   C. Oral surgeons may admit and perform histories and physicals, but are strongly urged to seek medical consultations for co-morbid conditions.

2. A patient admitted for podiatric care is a dual responsibility involving the podiatrist and physician member of the active staff.

   A. Podiatrist's responsibilities:

      (1) A detailed podiatric history justifying hospital admission;

      (2) A detailed description of the examination of the feet and pre-operative diagnosis;

      (3) A complete operative report, describing the findings and technique;

      (4) All tissue removed shall be sent to the hospital pathologist for examination;

      (5) Progress notes;

      (6) The podiatrist is solely responsible for the care of the human foot and leg, limited anatomically to that part below the anterior tibial tubercle (including amputation of the toes or other parts of the foot, not including amputation of the foot or leg in its entirety); and

      (7) Discharge summary or summary statement.

B. Physician's responsibilities:

(1) Medical history pertinent to the patient's general health;

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery;

(3) Supervision of the patient's general health status while hospitalized;

(4) Physicians are not responsible for any podiatric care or treatment of feet or consequences thereof; and

(5) Availability during the performance of a surgical procedure.

C. A podiatrist who has completed a two-year surgical residency may admit without the dual physician responsibility indicated in B, above. However, podiatrists are strongly urged to consult physicians if their patients have complex medical problems.

3. Admission and discharge of a podiatric or dental patient shall be the responsibility of the attending physician, who must be a member of the active staff with appropriate privileges to oversee the general medical care of the patient. Exception: Podiatrists who have been granted full history and physical privileges under paragraph 2C above may admit and discharge without an additional attending physician.

4. A physician shall retain full responsibility and accountability for the conduct and activities of the Physician Assistant and/or Nurse Practitioner, including moral and ethical behavior. A physician must provide verification of the credentials of the Physician Assistant and/or Nurse Practitioner to the clinical department to which he is assigned. The physician shall also designate members of the Staff assigned to his clinical department who are willing to assume responsibility for supervising the Physician Assistant and/or Nurse Practitioner in his absence.

5. Midwives. Delineation of privileges will be established by the Department of Obstetrics. The employer-physician will be notified of labor. The employer-physician must be notified of the patient's admission to the hospital, but need not be involved with the well-woman care in labor. The physician-employer must comply with Rules and Regulations, Medical Records and Orders.

6. A practitioner who is licensed to practice medicine in another jurisdiction, but not in this state, may participate as an observer in patient care. The out-of-state practitioner must be recommended to, and approved by the Chief of Staff. The practitioner must accompany the physician making the recommendation, who will be responsible for his activities.

7. Any Doctor of Medicine, Osteopathy, Podiatry, Dentistry or Oral Surgery licensed in the United States or Canada may refer patients to Gulf Coast Medical Center for noninvasive, outpatient diagnostic testing.

8. The medical staff may use HCIR's (Health Care Industry Representatives), subject to hospital policy and credentialing. The physician using the services of the HCIR is responsible for the actions of the HCIR. The physician performing the procedure must inform the patient that the HCIR will be present and explain his role in the procedure room.

CONSULTATIONS

1. Consultations shall be held, except in extreme emergencies, under the following conditions:

A. When the patient is not a good risk for operation or treatment;

B. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;

C. Where there is doubt as to the choice of therapeutic measures to be utilized;

D. In unusually complicated situations where specific skills of other practitioners may be needed;

E. In any instances in which the patient exhibits severe psychiatric symptoms;

F. Major surgical cases in which the patient is not a good risk or in which the diagnosis or indications for surgery are in doubt;

G. When requested by the patient or his family; and

H. When required by the policy of a special care unit.

2. Psychiatric consultation and treatment should be recommended to all patients who have attempted suicide or have taken a chemical overdose; that such services were at least recommended must be documented in the patient's medical records.

3. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so stated in the record, be recorded prior to the operation. Any qualified practitioner with clinical privileges in the Hospital may be called for consultation. The consultant must be qualified to give an opinion in the field in which his opinion and consultation is sought. The practitioner responsible for the care of the patient shall be responsible for judgments as to the serious nature of the illness and the question of doubt as to diagnosis and treatment.

4. Requests for emergency or urgent consultation should be accompanied by a personal telephone call to the consultant from the requesting Physician. Requests for consultation must contain a pertinent statement of the reason for the consultation and be directed to a specific physician. Consultation requests should also indicate a suggested timeframe in which the consultant may respond to the consultation request.

CONTINUING MEDICAL EDUCATION

1. All members of the Staff are encouraged to participate in pertinent self-assessment programs and in basic cardiopulmonary resuscitation training.

2. Continuing education requirements for all those credentialed under the Bylaws shall be in compliance with the requirements established by accreditation bodies and state licensing boards.

3. Each practitioner or other person with clinical privileges should participate in the Hospital's continuing education programs and in other continuing education activities that relate to the privileges granted.

4. Continuing medical education programs sponsored by the hospital will be based at least in part on the performance improvement findings and also relate to the type and nature of care provided by the hospital.