

**MAJOR HOSPITAL**  
**Shelbyville, IN**

**MEDICAL STAFF BYLAWS**

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MEDICAL STAFF BYLAWS**

**ADOPTED: JULY 26, 2010**

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## PREAMBLE

The physicians practicing at Major Hospital hereby organize themselves in conformity with the Bylaws hereinafter stated.

It is recognized that the members of the Medical Staff are responsible for the quality of medical care provided to patients by the Hospital. The Medical Staff also advises the Board of Directors on medical matters, including the monitoring of health care provided within the Hospital, and the credentialing and delineation of privileges for all health care providers within the Hospital. The members of the Medical Staff must accept and carry out such responsibility as the agents of the Hospital Board of Directors in cooperation with Hospital Administration in order to fulfill the Hospital's obligations to its patients. The Hospital Board of Directors and the Medical Staff, in order to promote professional peer review activity designed to establish a stable and harmonious environment in which appropriate levels of patient care may be achieved, hereby constitute themselves as professional review bodies as defined by the Health Care Quality Improvement Act of 1986 (42 U.S.C. Section 11101 et. seq.), and the Indiana Peer Review Act (I.C. 34-30-15et. seq.); and the Hospital Board of Directors and the Medical Staff claim all privileges and immunities afforded under those acts.

## TERM DEFINITIONS

Allied Health Professional – are individuals, other than licensed physicians, podiatrists, dentists, optometrists, or psychologists who are accorded specific clinical privileges in the Hospital within their licensed scope of practice, areas of training, and demonstrated competence.

Auxiliary Physician - means an individual with M.D. or D.O. degree, currently in a residency training program, who is licensed to practice medicine in the State of Indiana. An auxiliary physician provides additional support for physicians who maintain Medical Staff membership and clinical privileges.

Board of Directors – is the governing body of the Hospital, also called the Governing Body or Board.

Chief of Staff – means the chief officer of the Medical Staff elected by the members of the Medical Staff.

Hospital – means Major Hospital.

Licensed Independent Practitioner – means any practitioner permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the practitioner's license and consistent with individually assigned clinical responsibilities.

Medical Executive Committee – means the Executive Committee of the Medical Staff which shall constitute the governing body of the Medical Staff as described in these Bylaws.

Medical Staff – means those providers who have been granted recognition as members of the Medical Staff to the terms of these Bylaws.

Physician – means an individual with a M.D. or D.O. degree who is licensed to practice medicine in the State of Indiana.

President/CEO – means the person selected by the Board of Directors to serve in an administrative capacity.

Professional Staff – are individuals consisting of doctors of dentistry, podiatry, optometry and psychology licensed to practice in the State of Indiana.

## ARTICLE I

### NAME

The name of this organization shall be the Medical Staff of Major Hospital.

## ARTICLE II

### THE PURPOSE OF THIS MEDICAL STAFF SHALL BE

1. To ensure that all recipients of Hospital services shall receive care consistent with the highest standards afforded by the staff and facilities available to the Hospital, irrespective of race, color, creed, sex, national origin, sexual orientation, religion or source of payment of care. The Hospital shall admit patients suffering from all conditions within the treatment capabilities of its facilities, equipment and staff. Patients may be admitted only by physicians who have been duly appointed to membership on the Medical Staff or granted emergency or temporary privileges. Medical Staff members will comply with hospital admission and dismissal policies.
2. To provide a formal organizational structure through which the Medical Staff shall carry out their responsibilities and govern the professional activities of its members and other individuals with clinical privileges / specified services, and to provide mechanisms for accountability of the Medical Staff to the Board. These Bylaws shall reflect the current organization, functions, and rules and regulations of the Medical Staff.
3. To serve as a primary means of accountability to the Board concerning professional performance of the Medical Staff and others with clinical privileges / specified services authorized to practice at the Hospital with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in the quality assessment, performance improvement, risk management, case management, and other Hospital initiatives to measure and improve performance.
4. To establish and maintain high professional and ethical standards in general conformity with the requirements for Hospital and physician licensure in Indiana, Medicare Conditions of Participation, and any other standards as approved by the Board of Directors to the end that the Hospital shall maintain its status as an exemplary hospital.
5. To provide a means whereby issues of a medical administrative nature may be discussed by the Medical Staff with the Board of Directors and Administration.
6. To maintain educational standards of membership.
7. To assure a high level of performance by Medical, Professional, Auxiliary and Allied Health Staff members through appropriate delineation of staff privileges and the continuous review and evaluation of the Hospital activities.
8. To render such other services as are reasonably necessary to carry out the foregoing purposes.

## ARTICLE III

### MEDICAL STAFF MEMBERSHIP

#### Article III, Section 1

##### Nature of Medical Staff Membership

Membership on the Medical Staff is a privilege which shall be extended only to professionally competent physicians who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Acceptance to membership on the Medical Staff shall constitute the agreement of the member to strictly abide by the principles of ethics of the American Medical Association or the American Osteopathic Association, whichever is applicable, and adhere to the Hospital's pertinent corporate compliance policies and Health Insurance Portability and Accountability Act (HIPAA) rules and regulations.

#### Article III, Section 2

##### Qualifications and Continuing Responsibilities for Membership

Only physicians who shall be deemed to possess the following basic qualifications for appointment to the Medical Staff, except for the honorary/emeritus category (in which cases these criteria shall only apply as deemed individually applicable by the Medical Staff) shall be eligible for appointment to the Medical Staff:

- A. Possess an unlimited and unrestricted license to practice medicine in the State of Indiana. Physicians who have had limitations or restrictions placed on their licenses by appropriate legal authorities may continue to hold appointment on the Medical Staff, if recommended by the Medical Executive Committee and if approved by the Board of Directors;
- B. Can document (1) adequate experience, education, and training; (2) current professional competence; (3) good judgment; (4) character; (4) adequate physical and mental health status; (5) that they are professionally and ethically competent; and (6) that patients treated by them can reasonably expect to receive quality medical care;
- C. Agree (1) to adhere to the ethics of their profession; (2) to work cooperatively and effectively communicate with others so as not to affect patient care adversely; and (3) to participate in and properly discharge these responsibilities determined by the Medical Staff;
- D. Effective, January 1, 2007, all new applicants holding the degree of doctor of medicine or doctor of osteopathy who apply for Medical Staff membership to the Hospital must be board certified or eligible to take a specialty board examination necessary to achieve certification in the specialty acceptable to the department for which the applicant has applied for clinical privileges and the Medical Executive Staff. Medical Staff membership shall not be solely based on the fact that a physician is board certified.
  1. If not board certified, applicants are expected to successfully complete, pass and be awarded board certification by a specialty of the ABMS, AOA or other boards duly recognized by the Medical Executive Staff and the Board of Directors. When specialty boards have not established a time frame for obtaining initial board certification,

certification is to be obtained within five (5) years of being granted membership to the Medical Staff.

2. Once a member of the Medical Staff becomes Board certified recertification is not a requirement for continued membership and privileges.
3. Exceptions:
  - a. Members of Major Hospital's Honorary Medical Staff are exempted from the board certification requirements.
  - b. Notwithstanding anything to the contrary herein above, all Medical Staff members of Major Hospital who have an existing membership prior to January 1, 2007 shall be exempted from initial board certification requirements stated above, but must continue to document their background, experience, training, competency, adherence to professional ethics and good reputation to the satisfaction of the Medical Executive Committee and Board of Directors, in their sole discretion.
  - c. All existing members of the Medical Staff and future applicants may, in the sole discretion of the Medical Executive Committee and Board of Directors, be exempted from the requirement for board certification or recertification if substantiated by appropriate medical education and training, extraordinary experience and reputation, and additional evidence of current competency endorsed and presented in writing by the Service Chief/Director or his/her designee.

### Article III, Section 3

#### Effect of Other Affiliations

No physician shall be entitled to membership on the Medical Staff or to exercise clinical privileges in the Hospital merely by virtue of the fact that he/she is duly licensed to practice medicine in Indiana or in any other state, is a member of any professional organization, or has such clinical privileges at another hospital.

### Article III, Section 4

#### Nondiscrimination

No aspect of Medical Staff appointment or particular clinical privileges shall be denied on the basis of sex, race, creed, physical handicap, color, national origin, sexual orientation, or on the basis of any other criterion lacking professional justification.

### Article III, Section 5

#### Contract Physicians

A physician employed or under contract with the Hospital in a medico-administrative capacity or by virtue of a professional contract, must achieve and maintain Medical Staff membership through the same procedures provided for all Medical Staff members. Any physician whose engagement by the Hospital

requires membership on the Medical Staff as described above shall not have his or her Medical Staff membership and clinical privileges revoked without the same due process privileges provided for any other member of the Medical Staff, unless otherwise specified in the contract, in which case the terms of the contract supersede this provision.

### Article III, Section 6

#### Ethics

Acceptance of membership on the Medical Staff shall constitute the member's agreement that (s)he will strictly and continuously abide by the following ethics and responsibilities:

- A. Provides or arranges for continuous care and supervision of his/her hospitalized patients and to notify patients as to the reasons for any proposed change in the physician responsible for their care. All Practitioners shall refrain from delegating the responsibility for diagnosis and/or care of hospitalized patients to a Medical Staff Member, Professional Staff Practitioner, Allied Health Professional, Auxiliary Physician or any other paramedical person who is not qualified to undertake this responsibility or who is not adequately supervised.
- B. To comply with the Medical Staff Bylaws and all Medical Staff, Hospital, and applicable departmental policies and procedures.
- C. Agree with the principle not to engage in the practice of division of fees under any guise whatsoever; not to receive from, or pay to, another physician or any other person, either directly or indirectly, any part of a fee received for professional services except as otherwise permitted under federal, state, and local statutory or administrative law.
- D. The physician shall demonstrate the ability to work cooperatively and professionally with the Hospital Staff, its Professional / Allied Health Staff, and the Medical Staff, and refrain from disruptive behavior, which has or could interfere with patient care or the smooth operation of the Hospital and its Medical Staff.
- E. The applicant shall practice a branch of health care or a specialty which is consistent with the mission, vision, purposes, philosophy, treatment methods, and resources of the Hospital and for which the Hospital has a current need.
- F. The physician shall work cooperatively in the area of quality improvement and utilization management with the Medical Executive Committee and Administration to meet and practice within the guidelines established by the Hospital, its Medical Staff or local professional review organization. All members with clinical privileges will be subject to all applicable quality improvement activities, including peer review, and discharge such Staff, Service, department, committee or Hospital functions for which (s)he is responsible by appointment, election, or otherwise.
- G. Members of the Medical Staff shall: comply with all applicable state and federal laws and regulations; render care to patients that is consistent with applicable standards of quality and appropriateness; and disclose personal or professional conflicts of interest in fulfilling his or her function as a Medical Staff member and in the provision of patient care.
- H. The physician shall promptly notify the President/CEO of the revocation or suspension of his/her professional license, or the imposition of terms of probation or limitation of practice by any state

licensing agency; his/her loss of staff membership or loss, curtailment, or restriction of privileges at any hospital or health care institution; the cancellation or restriction of his/her liability coverage or DEA number; an adverse determination by a peer review organization or a third party payer reimbursement program concerning his/her quality of care; the commencement of a formal investigation or the filing of charges by the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or the State of Indiana, or any other state; or the filing of a claim against the physician alleging professional liability.

- I. Failure to comply with these ethics may result in dismissal from the Medical Staff of the Hospital.

### Article III, Section 7

#### Responsibilities

- A. Consultations. Requests or accepts appropriate requests for consultation per Medical Staff policy and procedure. A consultation with another qualified physician will be requested in cases when, according to the judgment of the physician, the patient is not a good risk for operation or treatment; the diagnosis is obscure or there is doubt as to the best therapeutic measures to be utilized. In addition in the Intensive Care Unit, mandatory peer or specialty consultation is required when the patient is not responding to treatment or meeting medical goals on the fourth day of ICU admission or if ICU length of stay is greater than four (4) days.
  1. Qualifications. A consultant must be well qualified in the field in which an opinion is sought.
  2. Responsibility for Requesting Consultations. The attending physician is responsible for requesting consultations when indicated.
  3. Requirements. A satisfactory consultation includes examination of the patient and his or her record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation notes, except in an emergency, shall be recorded prior to the operation. The attending physician must indicate one of the following consultation categories:
    - i. Consult and Participate in Management - consultant may write orders (explanation – overall chart completion remains with attending physician [i.e., discharge summary]).
    - ii. Consult and Manage – a specific condition or procedure (for example - insert central line or manage ventilator care, orders only for specific condition or procedure).
    - iii. Consult and Manage – consultant assumes full responsibility (explanation – attending and admitting physician may no longer writer orders).
    - iv. Consultation only – (explanation – no orders by consultant – only recommendations)

- B. Rounds. The attending physician or staff member designee shall make rounds on all attended inpatients at least every day. Only one Medical Staff member may be designated as the attending physician.
- C. Coverage and Assignment.
  - 1. Patients presenting for admission who have no attending physician shall be attended by members of the Active Staff in the service to which the needs of the patient indicates the assignment. The Service Chief shall have authority to call any member of the Medical Staff to attend a patient as is necessary.
  - 2. Each physician, except those specifically exempted by the Medical Executive Committee, shall be responsible to designate a member of the Active or Affiliate Staff as an alternate to attend patients when (s)he is not available.
- D. ACLS Transfers. An attending or a consulting physician shall be required to examine any newly admitted patient prior to an ACLS transfer.
- E. Medical Screenings. Medical screening examinations will be performed by personnel approved by the Medical Staff.
  - 1. The Medical Staff delegates to the Physical Therapists, Occupational Therapists and Speech Therapists evaluation, development and initiation of the plan of care in their respective disciplines if so ordered by the physician.
  - 2. The Medical Staff delegates to the dietitians the evaluation and ordering diets and nutrition supplements per Medical Staff policy and procedure.
  - 3. The Medical Staff delegates to approved Hospital staff the medical screening examination per Medical Staff policy and procedure.
- F. Medical Records. Prepares and completes in a timely fashion medical records for all the patients to whom the physician provides care in the Hospital per Medical Staff policy and procedure.

## ARTICLE IV

### MEDICAL STAFF CATEGORIES

#### Article IV, Section 1

##### Categories of the Medical Staff

#### A. Categories

The Medical Staff shall be divided into three (3) categories of membership: Active, Affiliate and Honorary. At the time of appointment and at the time of each reappointment, the Medical Staff member's staff category shall be recommended by the Medical Executive Committee and approved by the Board.

B. Limitations on Prerogatives

The prerogatives of Medical Staff membership in these Bylaws are general in nature and may be limited or restricted by special conditions attached to a physician's appointment or reappointment, by state or federal law or regulations, or other provisions of these Bylaws, policies, commitments, contracts or agreements of the Hospital.

C. Active Staff

1. Requirements for Active Status. The Active Medical Staff shall consist of physicians who are regularly involved in the care of patients at Major Hospital and who actively support the Medical Staff and the Hospital by contributing to efforts to fulfill Medical Staff functions. The Active Staff category of physicians shall be responsible for oversight of care, treatment and services provided by the Medical Staff and shall have the requisite skills for providing such oversight.
2. Prerogatives of Active Status. Members of the Active Medical Staff are privileged to admit patients in accord with the individual privileges and exercise such clinical privileges as are specifically granted. Active Medical Staff members are eligible to attend committee meetings, to serve, vote and hold office on committees of the Medical Staff.
3. Obligations of Active Status. Each member of the Active Staff shall discharge the obligations of Medical Staff membership as required in these Bylaws; participate in emergency on-call coverage for emergency care services within his/her clinical specialty as specified by the requirements of these Bylaws; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; actively participate in the quality assessment and performance improvement activities of the Hospital; and perform such further duties as may be required of him/her under these Bylaws including any future changes to these Bylaws; and comply with directives issued by the Medical Executive Committee.

D. Affiliate Staff

1. Requirements for Affiliate Status

The Affiliate Staff shall consist of those physicians who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions due to office-based specialty, practicing primarily at another hospital, or other reasons, but who wish to remain affiliated with the Hospital to conduct a routine specialty practice, for consultation purposes, referral of patients, or other patient care purposes.

2. Prerogatives of Affiliate Status

The Affiliate Staff are privileged to admit according to their clinical privileges. Members of the Affiliate Staff are eligible to attend and serve on committees of the Medical Staff and may attend General Medical Staff meetings. Members of the Affiliate Staff may be voting members of Standing Committees, excluding the Executive Committee. Members of the Affiliate Staff are not eligible to hold office within the Medical Staff organization.

3. Obligations of Affiliate Status

Each member of the Affiliate Staff shall discharge the obligations of Medical Staff membership as required in these Bylaws; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; and perform such further duties as may be required of him/her under these Bylaws.

E. Honorary Staff

1. Requirements for Honorary Staff

The Honorary Medical Staff shall consist of physicians who are not actively practicing in the Hospital and who are honored by emeritus position. These may include physicians who have retired from active hospital practice or who are of outstanding reputation, not necessarily residing in the community.

2. Prerogatives of the Honorary Staff

Honorary Staff members shall not be eligible to admit patients, vote, hold office, serve on standing committees or exercise clinical privileges in the Hospital. They may be appointed to special committees.

Article IV, Section 2

Changes of Category

- A. If a member desires to change staff category, (s)he must request the change in writing to the Medical Executive Staff and Board of Directors.
- B. Transfer of Active Medical Staff member shall occur after two (2) consecutive years in which a member of the Active Staff fails to provide care or consultation for patients in this Hospital or to be regularly involved in Medical Staff functions as determined by the Medical Executive Staff, that member may be automatically transferred to the appropriate category for which the member is qualified. The member will be notified in writing by Administration, on behalf of the Medical Executive Committee, of their change in Medical Staff category.

ARTICLE V

SPECIFIED PROFESSIONAL PRACTITIONERS

Article V, Section 1

Non-Member Professionals

Professional Staff Practitioners, Allied Health Professionals and Auxiliary Physicians may be appointed and granted clinical privileges or specified services to provide professional services in the Hospital.

## Article V, Section 2

### Professional Staff

The Professional Staff shall consist of doctors of dentistry, podiatry, optometry, and psychology licensed to practice in the State of Indiana who are appointed by the Board under the provisions of these Bylaws.

- A. Conditions of Appointment. Doctors of dentistry, podiatry, optometry, and psychology who are granted clinical privileges by the Board of Directors by a recommendation of the Medical Executive Staff shall be assigned to the Professional Staff category. Professional Staff practitioners shall carry professional liability insurance in limits acceptable to the Board and shall become and remain qualified health care providers as defined under the Indiana Medical Malpractice Act (I.C. 34-18 et. seq.). Professional Staff practitioners are not members of the Medical Staff, but are subject to the provisions of the Bylaws including investigations, actions, suspensions and appeals.
- B. Appointment and Reappointment. The factors to be considered in acting on the application or reappointment application of a member of the Professional Staff shall be the same as those set forth in these Bylaws for the appointment or reappointment, as applicable, for a Medical Staff member, modified only as necessary to reflect the particular professional field of the applicant.

## Article V, Section 3

### Dentists

- A. Qualifications. In order to be eligible for consideration for clinical privileges in the Hospital, a dentist must hold a currently valid license to practice dentistry in the State of Indiana, issued by the Board of Dental Examiners of the State of Indiana and must be a graduate of a school of dentistry approved by the American Dental Association and by the State Board of Dental Examiners.
- B. Dental Service. The practice of dentistry includes the diagnosis, prevention and treatment of any injuries, diseases or deformities of the teeth, the jaws and those structures generally involved in trauma or infection which are of dental origin. A dentist may write orders and prescribe medications within the limits of his or her license.

## Article V, Section 4

### Podiatrists

- A. Qualifications. In order to be eligible for consideration for clinical privileges in the Hospital, a podiatrist must hold a currently valid license to practice podiatry in the State of Indiana, issued by the Board of Medical Registration and Examination of the State of Indiana and must be a graduate of a school of podiatry approved by the Council of Education of the American Podiatry Association.
- B. Podiatric Service. The practice of Podiatry includes the diagnosis, prevention and treatment of any injuries, diseases or deformities of the foot. A podiatrist may write orders and prescribe medications within the limits of his or her license.

Article V, Section 5

Optometrists

- A. Qualifications. In order to be eligible for consideration for clinical privileges in the Hospital, an optometrist must hold a currently valid license to practice optometry in the State of Indiana issued by the Indiana Optometry Board, and must be a graduate of an accredited school of optometry as approved by the Council on Education.
- B. Optometric Service. The practice of Optometry includes the examination or diagnosis of the human eye to ascertain the presence of abnormal conditions or functions that may be diagnosed, corrected, remedied or relieved. An optometrist may write orders and prescribe medications within the limits of his or her license.

Article V, Section 6

Psychologists

- A. Qualifications. In order to be eligible for consideration for clinical privileges in the Hospital, a psychologist must hold a currently valid license to practice psychology in the State of Indiana issued by the Indiana State Psychology Board and must possess a doctoral degree in psychology granted from a recognized postsecondary educational institution; and from a degree program approved by the Indiana State Psychology Board as a psychology program at the time the degree was conferred.
- B. Psychology Service. The practice of psychology includes the observation, description, evaluation, interpretation and/or modification of human behavior by the application of psychological principles, methods, or procedures.

Article V, Section 7

Auxiliary Physicians

Auxiliary Physicians are physicians currently in a residency training program who provide additional support for physicians who maintain Medical Staff membership and clinical privileges. Auxiliary Physicians may be appointed and granted clinical privileges to provide professional services in the Hospital. The description of the role/ responsibility of these individuals does not lend itself to appointing these individuals to the Medical Staff and thereby receiving all the rights and privileges of membership. Auxiliary Physicians are nevertheless bound by the Medical Staff Bylaws.

- A. Conditions of Appointment. Physicians currently in a residency training program who provide additional support for physicians who maintain Medical Staff membership and clinical privileges at Major Hospital are eligible to be appointed as Auxiliary Physicians. Auxiliary Physicians are not members of the Medical Staff but are subject to the provisions of the Medical Staff Bylaws. They may only provide clinical services specifically approved by the Board of Directors and provide additional support when a full time physician is on duty or on call as specified per their clinical privileges. All Auxiliary Physicians authorized to provide care under supervision will have an annual competence/skill assessment.
- B. Qualifications. In order to be eligible for consideration for clinical privileges in the Hospital, an Auxiliary Physician must be licensed to practice medicine or osteopathic medicine in the State of

Indiana and document their background, experience, training, competence, adherence to professional ethics, and good reputation, with sufficient adequacy to assure the Medical Staff and the Governing Body that any patient treated by them in the Hospital will be given high quality of medical care. The Auxiliary Physician shall carry professional liability insurance and shall become and remain a qualified health care provider as defined under the Indiana Medical Malpractice Act (I.C. 34-18 et. seq.).

- C. Supervision. An Auxiliary Physician who is a licensed independent practitioner may be granted clinical privileges to perform clinical services in the Hospital under supervision and direction of the departmental physician on duty or on call, as specified per the Auxiliary Physician's clinical privileges.
- D. Appointment and Reappointment. The appointment and reappointment of an Auxiliary Physician shall be made and evaluated pursuant to Article VI of the Bylaws.

#### Article V, Section 8

##### Allied Health Professionals

Allied Health Professionals shall consist of those professionals who, when practicing within the scope of their licenses and specified services provide direct patient care under the supervision or sponsorship of a member of the Medical Staff. These might include certified physicians assistants, licensed nurse practitioners, and certified registered nurse anesthetists. Allied Health Professionals may only engage in acts within their respective scopes of practice and as specifically approved by the Medical Staff and Board of Directors and/or any applicable governmental law or regulation. All Allied Health Professionals authorized to provide care under supervision will have an annual competence/skill assessment. They shall not be eligible for membership on the Medical Staff but are subject to the provisions of the Medical Staff Bylaws.

- A. Supervision. Allied Health Professionals may be assigned limited clinical privileges to perform specified services in the Hospital under the supervision and direction of a member of the Medical Staff or Professional Staff. If the Medical Staff membership of the supervisor is terminated for any reason, or if the supervisor's clinical privileges are curtailed to the extent that the professional services of the dependent Allied Health Professional within the Medical Staff are no longer necessary or permissible to assist the supervisor, the clinical duties and responsibilities of said individual shall be terminated unless supervision is transferred to another member of the Medical Staff.
- B. Assignment to Clinical Service. Upon receiving approval of the Medical Executive Staff and the Board of Directors, an Allied Health Professional shall be assigned as an affiliate to the clinical service(s) in which his or her physician employer or supervisor is a member.
- C. Standards and Criteria. The standards and criteria for the qualifications, duties, responsibilities, privileges and the monitoring of the conduct of an Allied Health Professional shall be those established by the Medical Staff and approved by the Board of Directors.
- D. Appointment and Reappointment. The appointment and reappointment of an Allied Health Professional shall be made and evaluated pursuant to Article VI of the Bylaws and further specified below:

1. Application. An application for clinical privileges may be made by a Medical Staff member or Professional Staff Practitioner, who is the Allied Health Professional's employer, and the Allied Health Professional. The applicant must list the specific clinical privileges being requested. As a continuing condition of eligibility for Allied Health Professional status, the physician or practitioner employer / supervisor must be, and remain, a member in good standing of the Medical Staff or Professional Staff and of the clinical department in which clinical privileges are being requested.
  2. Responsibility. By being appointed the Allied Health Professional and his or her physician or practitioner employer / supervisor shall be deemed to have agreed to be responsible for all acts while attending patients in the Hospital and to hold the Hospital, its officers, agents and employees harmless from any loss, cost, claims, or liability of any nature whatsoever arising out of acts or omissions while attending patients in the Hospital.
  3. Appeals. If an application for appointment and/or clinical privileges is denied, the physician or practitioner employer / supervisor may request a hearing in accordance with Article V, Section 8 J. 2. herein.
- E. Nurse Anesthetist. In order to be eligible for consideration for clinical privileges in the Hospital, a nurse anesthetist must hold a currently valid license to practice as a registered nurse in the State of Indiana, must hold a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by the Medical Licensing Board of Indiana. A nurse anesthetist must be certified by the American Association of Nurse Anesthetists. Nurse Anesthetists will be supervised in the surgical suite by a surgeon. Nurse Anesthetists shall also carry professional liability insurance and shall become and remain a qualified health provider as defined under the Indiana Medical Malpractice Act (I.C. 34-18 et. seq.).
- F. Nurse Practitioner. In order to be eligible for clinical privileges in the Hospital a nurse practitioner must be Board Certified, hold a current Indiana State license as a registered nurse and be designated as a Nurse Practitioner in the State of Indiana. The Nurse Practitioner shall carry professional liability insurance and shall become and remain a qualified health care provider as defined under the Indiana Medical Malpractice Act (I.C.27-12 et. seq.).
- G. Clinical Nurse Specialist. In order to be eligible for clinical privileges in the Hospital a clinical nurse specialist must hold a Masters Degree in Nursing that prepares (s)he as a clinical nurse specialist, hold a current Indiana State license as a registered nurse and be designated as a Clinical Nurse Specialist in the State of Indiana. The Clinical Nurse Specialist shall carry professional liability insurance and shall become and remain a qualified health care provider as defined under the Indiana Medical Malpractice Act (I.C. 34-18 et. seq.).
- H. Physician Assistant. In order to be eligible for consideration for clinical privileges in the Hospital a physician assistant must be a graduate of a physician's assistant training program, must have successfully completed the national examination administered by the National Commission on the Certification of Physician's Assistants and must have registered with the Indiana Physician Assistant Committee and otherwise be in compliance with I.C. 25-27.5-1 et. seq. and the rules and regulations promulgated by the Indiana Medical Licensing Board or Physician Assistant Committee of Indiana. The Physician Assistant shall carry professional liability insurance and shall become and remain a qualified health care provider as defined under the Indiana Medical Malpractice Act (I.C. 34-18 et. seq.).

I. Other Allied Health Professionals. Other non-physician health professionals not listed above may be granted clinical privileges by the Board of Directors, based on a documented need for their services and in accordance with the requirements set forth in these Bylaws.

J. Discipline

1. Whenever the activities or conduct of an Allied Health Professional are considered to be in violation of the Bylaws, the Chief of Staff or appropriate Service Chief may summarily suspend the privileges of the Allied Health Professional, after giving the physician employer / supervisor and the Allied Health Professional notice in writing of the effective date of the suspension and the reasons for the suspension.
2. The physician or practitioner employer / supervisor of the Allied Health Professional may, within five (5) days after receipt of such notice, request a hearing by the Executive Committee. The physician or practitioner employer / supervisor and the Allied Health Professional shall be given at least a three (3) day written notice of the time and place of the hearing. The hearing shall be held as soon as is practical and reasonable under the circumstances and shall be conducted informally as a professional discussion. The Executive Committee may modify, terminate, or affirm the terms of the suspension and the decision of the Executive Committee shall be final.
3. The physician or practitioner employer / supervisor and the Allied Health Professional shall, in applying for clinical privileges be deemed to have agreed to the provisions herein for discipline and suspension and to have agreed that it is in the best interest of good patient care that such disciplinary measures be taken without risk of personal liability on the part of members of the Medical Staff or the officers or employees of the Hospital and that all such persons shall be immune from civil liability arising from any acts, reports, communications or recommendations made in good faith hereunder.

## ARTICLE VI

### PROCEDURE FOR APPOINTMENT & REAPPOINTMENT AND GRANTING CLINICAL PRIVILEGES

#### Article VI, Section 1

##### Conditions and Duration of Appointment

- A. The Board of Directors shall make initial appointments and reappointments to the Medical Staff. The Board of Directors shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Executive Committee, as provided herein.
- B. Initial appointments and reappointments shall be for a period of not more than two (2) years.
- C. Appointment to the Medical Staff shall confer upon the appointee only such privileges as are merited by education, training, and demonstrated current competence. A clear distinction shall be made between an appointment to the Medical Staff and the specific privileges to attend patients.

- D. Every application for appointment to the Medical Staff shall be signed by the applicant and shall contain the applicant's specific acknowledgement of his/her obligation to provide continuous care and supervision of his/her patients and to abide by the Medical Staff Bylaws.
- E. The procedure for making application to the Medical Staff and for the appointment and reappointment of members is specified within these Bylaws.

Article VI, Section 2

Initial Appointment Information Requirements

- A. A signed, written application is to be submitted on the prescribed form to the President/CEO through Administration/ Medical Staff Office.
- B. The application shall require detailed information concerning the professional qualifications of the applicant, including but not limited to:
  - 1. Current license(s), licensure sanction(s), state(s) of current practice or intended practice, and all previous licenses held.
  - 2. Challenges to or relinquishment of DEA / controlled substances registration.
  - 3. Information involving voluntary or involuntary termination of Medical Staff status or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital / facility.
  - 4. Involvement in professional liability action to include final judgments, settlements, and pending claims.
  - 5. Challenges to or relinquishment, either voluntary or involuntary, of registration or license to practice medicine in any state.
  - 6. History of all past professional sanctions or disciplines issued by licensing boards or specialty boards or loss of board certification.
  - 7. History of suspension, probation, resignation or being reprimanded during medical education or post-graduate training.
  - 8. History of any felony conviction(s) and/or investigation(s), present or past.
  - 9. History of sanctions, suspensions, restrictions or subject of an investigation by any private, federal or state health insurance program.
  - 10. Personal attestation regarding health status and/or current substance abuse problem.
  - 11. Names, addresses and contact numbers of at least three medical or health care professionals who have personal knowledge of the applicant's current clinical abilities, ethical character, health status, and ability to work cooperatively with others and who will provide specific written comments on these matters. The named individuals must have acquired the requisite knowledge through recent observation over a reasonable

period of time, and at least one of which shall be an individual with the same professional credentials.

12. Information regarding all current and past healthcare affiliations, including the names and addresses of the facilities and dates of affiliation.
13. Information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of certification.
14. Information regarding clinical privileges desired, coverage arrangements, clinical service(s) assignment and category of staff requested.
15. Personal attestation regarding current professional liability coverage and a personal attestation regarding professional claims history. Each applicant, except licensed independent practitioners providing telemedicine services, shall become and remain a qualified health care provider under the Indiana Medical Malpractice Act (I.C. 34-18 et seq.).
16. Information regarding past two (2) years of CMEs earned, unless just completed post-graduate training program.
17. And such other information as deemed appropriate by the Medical Executive Committee and Board of Directors.

#### Article VI, Section 3

##### Statement of Release and Immunity from Liability

To the fullest extent permitted by law, the applicant agrees to release, from civil liability, all authorized representatives of the Hospital and Medical Staff acting in official capacity for any acts, communications, reports, recommendations, or disclosures performed, made or received in good faith, concerning activities related to:

- A. Applications for appointment or clinical privileges, including temporary privileges;
- B. Periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;
- C. Proceedings for suspension of clinical privileges or revocation of staff membership;
- D. All actions, including suspensions, affecting the privileges or status of a Medical Staff member and the hearing and appellate procedures relating thereto;
- E. The applicant's professional performance and conduct in other activities conducted under Hospital auspices relating to the quality of patient care or the professional conduct of a physician; and
- F. Release of information to other medical institutions regarding the applicant's professional qualifications, competency and character.

Article VI, Section 4

Application Process

- A. A separate credentials file shall be maintained for each applicant for Medical Staff membership or clinical privileges. Every application for staff appointment shall be signed by the applicant and shall constitute the applicant's:
  - 1. Specific acknowledgement of the obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the Hospital for whom (s)he is responsible;
  - 2. Agreement to accept committee assignments and other duties and responsibilities as assigned;
  - 3. Acknowledgement of having received and read a copy of the Medical Staff Bylaws and agree to be bound by the terms thereof;
  - 4. Statement of willingness to appear for personal interviews in regard to the application; and
  - 5. Consent authorizing the Hospital and Medical Executive Staff to consult with other hospitals with which the applicant has been associated, and with others who may have information bearing on his or her competence, character and ethical qualifications and to inspect records and documents that may be material to an evaluation of his or her professional competence, character and qualifications for staff membership.
- B. The applicant shall have the burden of providing evidence that all the statements made and information given on the application are factual and true.
- C. The applicant shall have the burden of providing adequate information for proper evaluation of his or hers:
  - 1. Background education, training, experience, and current clinical competence.
  - 2. Ethical character.
  - 3. Mental and physical health status.
  - 4. Clinical and administrative performance.
  - 5. Any other areas of inquiry deemed appropriate by the Medical Executive Committee and the Board of Directors.
- D. The application will be considered complete when all reference materials and verifications have been received and all information requested by the Service Chief/Director, Medical Executive Committee, and Governing Board has been received to the satisfaction of the requesting individual or body.

1. The Administrative Assistant or Administrative Secretary shall review the submitted application with the Service Chief/Director in the area of the requested privileges who will:
  - i. Evaluate the contents of the credentials file to assess the applicant's entry-level qualifications in relation to the clinical privileges requested.
  - ii. As a member of the Medical Executive Committee, make a recommendation to the committee regarding appropriateness of requested clinical privileges in relation to entry-level qualifications and the need for supervision or limitation of privileges, if indicated. If the Service Chief/Director is not a member of the Medical Executive Committee, the application and the recommendation will be forwarded to the Secretary of the Medical Executive Committee for presentation to the committee.
- E. The application will be forwarded to the Medical Executive Committee for investigation of the personal character, credentials, qualifications and background of the applicant. The Executive Committee may interview the applicant and take necessary actions to verify whether the applicant meets the qualifications for the category of membership and clinical privileges requested. Where appropriate, the Executive Committee may require an impartial physical or mental examination of the applicant to ensure that the applicant is free of or has under adequate control, with or without a reasonable accommodation, any physical or mental disability which would interfere with the applicant's ability to meet the requirements under these Bylaws.
- F. Within sixty (60) days after receipt of the application by the Department Chief/Director, the Medical Executive Committee shall submit a report of its findings to the Governing Body and shall recommend that the application be accepted, deferred or rejected.
- G. At its regular meeting after receipt of the recommendation, the Executive Committee of the Medical Staff shall determine whether to defer the application for further consideration or recommend to the Governing Body that the applicant be appointed to the Medical Staff.
  1. When the recommendation is favorable to the applicant, it shall be transmitted to the Governing Body, together with all supporting documentation, through the President/CEO.
  2. When the recommendation is to defer the application for further consideration, the Executive Committee of the Medical Staff must reconsider the application within thirty (30) days and make a subsequent recommendation for acceptance or rejection of the application.
  3. When the recommendation is adverse to the applicant with respect to either appointment or clinical privileges, the President/CEO shall notify the applicant by certified mail within seven (7) days of the recommendation. The President/CEO shall then hold the application until after the applicant has exercised or has been deemed to have waived his or her right to a hearing as provided in Article IX of the Bylaws, or Article V, Section 8 of the Bylaws in the case of Allied Health Professionals. When the applicant has been deemed to have waived his or her right to a hearing, the President/CEO shall forward the recommendation to the Governing Body.

The notification must be signed by the Chief of Staff and state the following:

- i. that an adverse recommendation has been proposed;
- ii. the reasons and basis for the adverse recommendation;
- iii. that the affected practitioner has a right to request a hearing on the adverse recommendation within thirty (30) days of receipt of the notification; and
- iv. a summary of the hearing rights provided under Article IX of these Bylaws.

#### Article VI, Section 5

##### Governing Body Action

When final action has been taken by the Governing Body, the President/CEO shall notify the applicant of the decision.

#### Article VI, Section 6

##### Reappointment Process

Medical Staff Members, Professional Staff Practitioners, Allied Health Professionals and Auxiliary Physicians shall be reappointed by the Board of Directors no less frequently than every two (2) years.

- A. Administration/Medical Staff Office will provide application forms for reappointment to members and other practitioners prior to October 1st, according to original appointment year.
- B. If a member or practitioner desires to be considered for a change in staff category or clinical privileges, (s)he shall so indicate on the reappointment application.
- C. The member or practitioner will provide copies of all documents renewed between reappointments; i.e., license, DEA, insurance at the time or renewal, any requested change in clinical privileges. All requests for new or expanded privileges must be accompanied by evidence of sufficient training and experience in the performance of such privileges. At the time of reappointment, the Administrative/Medical Staff Office will verify current licensure in the State of Indiana, insurance, currency of Board certification, eligibility or admissibility, and will query the NPDB and other verifications as outlined in the Hospital's reappointment policies and procedures.
- D. Recommendations concerning the reappointment of a Medical/Professional/Auxiliary/ Allied Health Professional Staff shall be based upon the reappointment application submitted by the practitioner and the reappointment parameters as stated in the Hospital's reappointment policies and procedures regarding reappointments.
- E. After the practitioner's file has been reviewed by the Service Chief/Director or Medical Executive designee, the file will be forwarded to Executive Committee for review and recommendation to the Governing Body.

## ARTICLE VII

### CLINICAL PRIVILEGES

#### Article VII, Section 1

##### Delineation of Privileges

- A. Every practitioner practicing at the Hospital by virtue of Medical Staff membership or otherwise, shall be entitled to exercise only those clinical privileges specifically granted by the Governing Body, except as provided in Sections 3 and 4 of this Article.
- B. Every initial application for appointment and reappointment to the Medical Staff, Professional Staff, or as an Allied Health Professional must contain a request for the specific clinical privileges desired by the applicant. Board certification or licensure in and of itself is not recognized as an appropriate basis to grant any or all of the privileges requested. The evaluation of such requests or requests for additional privileges shall be based upon the applicant's education, training and experience, demonstrated current competence, references and other relevant information. Such evaluation shall also include an analysis of the ability of the Hospital to provide adequate facilities and supportive services in regards to the clinical privileges sought. The applicant shall have the burden of establishing his or her qualifications and competence in the clinical privileges (s)he requests.
- C. Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon direct observation of care provided, review of medical records, and quality assessment/improvement and outcomes. Any reduction in clinical privileges is subject to the due process provisions of Articles VIII and IX, as applicable.
- D. A request by a member for a modification of clinical privileges may be made at any time, but requests for additional privileges must be supported by documentation of training and experience supportive of the request and will be evaluated on the same criteria as requests for initial privileges per Hospital policy and procedure.

#### Article VII, Section 2

##### Telemedicine Privileges

Telemedicine is the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services.

Credentialing and privileging to provide telemedicine services at the Hospital may be through one of the following mechanisms:

- A. As the originating site, the Hospital, fully privileges and credentials the physicians and practitioners according to these Bylaws and standard policies and procedures, or
- B. By written contractual agreement with a distant-site hospital/telemedicine entity, in accordance with the requirements at §482.22(a)(1) and §482.22(a)(2) of the Code of Federal Regulations, the Medical Executive Committee will rely upon the credentialing and privileging decisions made by the distant-site hospital/telemedicine entity when making a recommendation on privileges for the

individual distant-site physicians and practitioners providing such services, if Major Hospital's Board of Directors ensures, through its written agreement with the distant-site hospital /telemedicine entity, that all of the following provisions are met:

- The distant-site hospital providing the telemedicine services is a Medicare participating hospital, or;

The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at §482.12(a)(1) through (a)(7) and §482.22(a)(1) through (a)(2) of the Code of Federal Regulations.

- The individual distant-site hospital/telemedicine entity physician or practitioner is privileged at the distant-site hospital/telemedicine entity providing the telemedicine services, provides the Hospital with a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital/telemedicine entity.
  - The individual distant-site physician or practitioner must have a current, valid Indiana license.
  - Major Hospital provides evidence of an internal review of the distant-site physician's or practitioner's performance of his/hers current privileges for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information will include all adverse events and complaints that result from the telemedicine services provided by the distant-site physician or practitioner to the Hospital's patients.
1. The Medical Executive Committee will make its recommendation, according to the requirements in §482.12(a)(8) and (a)(9) and §482.22(a)(3) and (a)(4) of the Code of Federal Regulations, to the Board of Directors based on credentialing and privileging information provided by the distant-site hospital/telemedicine entity.
  2. The granting of clinical privileges will be for the same period of time as the granting of privileges, that occurs no less frequently than every two (2) years, by the distant-site hospital/telemedicine entity providing telemedicine services. Upon presentation of evidence of the extension or renewal of privileges granted by the distant-site hospital/telemedicine entity, the Medical Executive Committee will make its recommendation to the Board of Directors based upon the credentialing and privileging reappointment decisions made by the distant-site hospital/telemedicine entity.
  3. Physicians and practitioners receiving clinical privileges at Major Hospital in this manner will not be members of the medical staff and will have no rights afforded to members. However, physicians and practitioners must comply with all provisions of the Medical Staff Bylaws and medical staff policies and procedures applicable to the exercise of their clinical privileges at Major Hospital.
- C. Practitioners with telemedicine privileges who elect to apply for medical staff membership will be assigned to the Affiliate Staff.
- D. Telemedicine practitioners are required to be qualified providers under the Indiana Medical Malpractice Act (I.C. 16-9.5) or submit proof of maintaining current professional liability

coverage per amounts outlined in the Hospital's corresponding medical staff telemedicine policy and procedure.

- E. If the Hospital has a pressing clinical need and a physician or practitioner can supply that service through telemedicine, the Hospital can evaluate the use of temporary privileges for this situation.

#### Article VII, Section 3

##### Temporary Privileges

- A. The Chief of the Medical Staff (or designee in his/her absence) with the concurrence of the President (or designee in his/her absence) may grant temporary privileges to a new applicant for Medical, Professional, Auxiliary or Allied Health Professional Staff membership during review or consideration of the application.
- B. The granting of temporary privileges is not precipitous but occurs after verification of licensure, medical education, NPDB, OIG, AMA, DEA, insurance and at least one reference from a previous facility, chief or department chair.
- C. Limits to number of specific patients that may be cared for are identified.
- D. Special requirements of supervision and reporting may be imposed by the Chief of Staff on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the President/ CEO upon notice of any failure by the practitioner to comply with such special conditions.
- E. Locum tenens privileges may be granted for specific periods of time, which are not typically sequential so as to bypass the need for application for appointment, provided that such privileges are not granted for a period of greater than 120 days.
- F. The termination, reduction, or denial of temporary privileges shall not give rise to the hearing and appeal procedures of Article VIII of these Bylaws, unless such termination, reduction or denial is based on the professional competence or conduct of the practitioner.

#### Article VII, Section 4

##### Emergency Services

In the case of an emergency, any physician, dentist, podiatrist, optometrist or Allied Health Professional, to the degree permitted by his or her license and regardless of staff status or lack thereof, shall be permitted to do everything possible to save the life of a patient using every facility of the Hospital necessary, to include calling for consultation. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are not requested or are denied, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition in which serious 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. Patients with an "urgent" condition are patients for whom definitive care may be delayed for up to two (2) hours without negative outcome.

Article VII, Section 5

Emergency Management Plan

Emergency privileges of licensed independent practitioners may be granted when the Hospital's Emergency Management Plan is activated and the organization is unable to handle immediate patient needs. The President/CEO or designee may grant emergency temporary privileges to a physician based upon presentation of appropriate identification and licensure as outlined in Hospital policy. Formal verification of credentials and privileges will begin as soon as the immediate emergency situation is under control.

ARTICLE VIII

CORRECTIVE ACTION

Article VIII, Section 1

Corrective Action

- A. Criteria For Initiation. When reliable information indicates a Medical Staff Member may have exhibited acts, demeanor or conduct, reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) disruptive to Hospital operations (including action injurious to the Hospital's or Medical Staff's reputation); (3) unethical; (4) contrary to the Medical Staff Bylaws; or (5) below applicable professional standards, a request for an investigation or action against such member may be initiated by any Medical Staff Officer, any Service Chief or Director, the President/CEO, the Chairman of any Medical Staff Committee, or the Governing Body. Any person may supply the information relied on to initiate the request.
- B. Initiation. A request for an investigation must be submitted to the Medical Executive Committee and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall record the reasons.
- C. Investigation. If the Executive Committee concludes that an investigation is warranted, it shall direct an investigation to be undertaken. The Executive Committee may conduct the investigation itself or may assign the task to an appropriate staff officer, department or standing or ad hoc committee of the Medical Staff. If the investigation is delegated to an officer or committee other than the Executive Committee, such officer or committee shall promptly investigate the matter and forward a written report of the findings from the investigation to the Executive Committee as soon as practical. The report may include recommendations for appropriate corrective action.

If corrective action is being contemplated, the member shall be notified by the Executive Committee or its designee that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating individual or body deems appropriate. The individual or body investigating the matter shall offer an interview to the practitioner. Such interviews shall not constitute a "hearing" as that term is used in Article IX nor shall any of the procedural rules for hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee retains its authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension or termination of the investigative process.

The Executive Committee may at any time within its discretion, and shall at the request of the Board of Directors, terminate the investigative process and proceed with action as provided in Section 1 D of this Article.

- D. Medical Executive Committee Action. As soon as is practical after the conclusion of the investigation, the Medical Executive Committee shall take action which may include, without limitation:
1. Determining no corrective action should be taken and, if the Executive Committee determines there was no credible evidence for the complaint in the first instance, clearly documenting those findings in the member's file.
  2. Deferring action for a reasonable time not to exceed ninety (90) days where circumstances warrant.
  3. Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude the Medical Staff, Service Chiefs, Directors or Committee Chairmen from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file.
  4. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.
  5. Recommending reduction, modification, suspension or revocation of clinical privileges.
  6. Recommending suspension, revocation or probation of Medical Staff membership.
  7. Taking other actions deemed appropriate under the circumstances.
- E. Subsequent Actions.
1. In the event the Medical Executive Committee determines that no corrective action is required, or a letter of warning, admonition, reprimand or censure should be issued, that decision shall become final subject to review by the Board. The Board may affirm, modify, further investigate, or reject the recommendation referred for review.
  2. If the Medical Executive Committee recommends action which constitutes grounds for a hearing under Article IX, the Board shall not act on the matter until the practitioner has waived his/her hearing rights or invoked his/her hearing rights and the matter is set for appellate review.
- F. Procedural Rights. Any recommendation by the Executive Committee which constitutes grounds for a hearing as set forth in Article IX, Section 4 shall entitle the practitioner to the procedural rights as provided in Article IX. In such cases, the President and Chief of Staff and/or the President/CEO shall give the practitioner special notice of the adverse recommendation and of his/her rights to request a hearing in the manner specified in Article VIII.

Article VIII, Section 2

Summary Suspension

- A. Criteria For Initiation. Whenever a practitioner's conduct requires immediate action to be taken to reduce a substantial likelihood of imminent impairment of the health or safety of any patient, prospective patient, employee or other person present in the Hospital, the Executive Committee shall have the authority to summarily suspend the Medical Staff membership or all or any portion of the clinical privileges of such practitioner. In cases of extreme emergency, the Chief of Staff or the President of the Board, or his or her designee, may remove a member from the premises.

Such summary suspension shall become effective immediately upon imposition, and the person or body responsible therefore shall promptly give oral or written notice of the suspension to the practitioner, the Executive Committee, and the President/CEO. It should inform the practitioner of his or her right to Executive Committee review under Article VIII, Section 2 B. The notice of the suspension given to the Executive Committee shall constitute a request for corrective action and the procedures set forth in Article VIII, Section 1 shall be followed. Actions to suspend or remove a member shall be for the purpose of investigation only and shall not imply any final findings with respect to the situation that was cause for the suspension.

In the event of any suspension, the practitioner's patients whose treatment is affected by the summary suspension shall be assigned to another practitioner by the Service Chief or Director. The wishes of the patient and the physician shall be considered, where feasible, in choosing a substitute practitioner.

- B. Medical Executive Committee Action. A practitioner who has been summarily suspended may request an interview with the Executive Committee. Such interview shall be informal and shall not constitute a hearing as provided in Article IX. The interview shall be convened as soon as reasonably possible under all of the circumstances, not to exceed thirty (30) days. The Executive Committee may thereafter modify, continue, or terminate the terms of the summary suspension order and it shall give the practitioner written notice of its decision.
- C. Procedural Rights. Unless the Executive Committee terminates the suspension, it shall remain in effect during the pendency of and the completion of the corrective action process and of the hearing and appellate review process, unless the summary suspension is terminated by the decision of the Judicial Hearing Committee.

Article VIII, Section 3

Automatic Suspension

- A. License.
1. Revocation or Expiration: Whenever a practitioner's license authorizing him/her to practice in this state is revoked or has expired, his/her Medical Staff membership, prerogatives, and clinical privileges shall be immediately and automatically terminated. Such practitioners shall not be entitled to the procedural rights afforded by Article IX.
  2. Restriction: Whenever a practitioner's license authorizing him/her to practice in this state is limited or restricted by the applicable licensing authority, those clinical

privileges which he/she has been granted rights to perform that are within the scope of said limitation or restriction shall be immediately and automatically terminated.

3. Suspension: Whenever a practitioner's license authorizing him/her to practice in this state is suspended, his/her staff membership and clinical privileges shall be automatically suspended effective upon and for the term of the suspension.
4. Probation: Whenever a practitioner is placed on probation by the applicable licensing authority, his/her applicable membership status, prerogatives, privileges and responsibilities, if any, shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation.

B. Drug Enforcement Administration (DEA) And Indiana Controlled Substance Certificate.

1. Revocation or Expiration: Whenever a practitioner's DEA certificate and/or Indiana Controlled Substance Certificate is revoked or has expired, he/she shall immediately and automatically be divested of his/her right to prescribe medications covered by the certificate.
2. Suspension: Whenever a practitioner's DEA certificate and/or Indiana Controlled Substance Certificate is suspended, he/she shall be divested, at a minimum, of his/her right to prescribe medications covered by the certificate effective upon and for at least the term of the suspension.
3. Probation: Whenever a practitioner's DEA certificate and/or Indiana Controlled Substance Certificate is subject to an order of probation, his/her right to prescribe medications covered by the certificate shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation.

C. Executive Committee Deliberation on Matters Involving License or Drug Enforcement Administration Actions. As soon as practical after action is taken as described in Article VIII, Section 3 A (2 & 3) or in Article VIII, Section 3 B, the Executive Committee shall convene to review and consider the facts upon which such action was predicated. The Executive Committee may then recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available to it and/or it may direct that an investigation be undertaken pursuant to Article VIII, Section 1 C. The Executive Committee review and any subsequent hearing and appeal shall not address the propriety of the licensure or DEA or Indiana Controlled Substance Certificate action, but shall address instead what action the Hospital should take.

D. Medical Records. All medical records shall have documented completion within 30 days following discharge. The discharge summary will be completed within 7 days of discharge to ensure continuity of care. The medical history and physical has to be completed within 30 days of admission or within 24 hours of admission or registration. When the medical history and physical is completed within 30 days of admission, an updated history and physical examination is required within 24 hours of admission or registration, but prior to surgery or a procedure requiring anesthesia services. Co-signatures are required on all orders, history and physicals, discharge summaries and progress noted completed by physician assistants, and on history and physicals, discharge summaries and progress notes completed by nurse practitioners. All operations performed shall be fully described by the operating surgeon in an operative summary.

For normal newborns with uncomplicated deliveries or for patients hospitalized for less than 48 hours with only minor problems (uncomplicated), a Progress Note may substitute for a Discharge Summary. The Discharge Summary must document the patient's condition at discharge, discharge instructions and follow-up care required. A Discharge Summary or a Short Stay must be done on patients that are admitted and/or have surgery as this is not considered a minor or uncomplicated stay. The Discharge Summary, Short Stay must be signed by the physician. Incomplete and delinquent records are monitored and reported to the physician and Administration by Health Information. Potential sanctions include, but not limited to, suspension of clinical privileges until all delinquent medical records are completed.

- E. Malpractice Insurance. Except for telemedicine physicians who are exempt from participation, failure to remain a qualified health care provider under the Indiana Medical Malpractice Act, a practitioner's membership and clinical privileges, shall be automatically suspended and shall remain so suspended until the practitioner provides evidence to the Executive Committee that (s)he has secured professional liability coverage in the amount required. A failure to provide such evidence within six (6) months after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership.
- F. Procedural Rights -- Medical Records and Malpractice Insurance. Practitioners whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provisions of Article VIII, Section 3 E. (failure to maintain malpractice insurance) shall not be entitled to the procedural rights set forth in Article IX.
- G. Notice of Automatic Suspension; Transfer of Patients. Whenever a practitioner's privileges are automatically suspended, in whole or in part, notice of such suspension shall be given to the practitioner, the Executive Committee, the President/CEO, and the Governing Body. Giving of such notice shall not, however, be required in order for the automatic suspension to become effective. In the event of any such suspension, the practitioner's patients whose treatment is affected by the automatic suspension shall be assigned to another practitioner by the Chief of Staff. The wishes of the patient and the practitioner shall be considered, where feasible, in choosing a substitute practitioner.

#### Article VIII, Section 4

##### Disruptive / Impaired Medical Staff Member

Members of the Medical Staff who engage in inappropriate or disruptive conduct are subject to one or more of the following: collegial intervention, referral to the Indiana State Medical Association ("ISMA") Physician's Assistance Program or formal disciplinary action.

#### Article VIII, Section 5

##### Interviews

Interviews shall neither constitute nor be deemed a "hearing," as that term is used in Article IX, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. The Executive Committee shall be required, at the practitioner's request, to grant him/her an interview only when so specified in this Article VIII. In all other cases and when the Executive Committee or the Board has before it an adverse recommendation, as defined in Article IX, Section 4, it may, but shall not be required to, furnish the practitioner an interview. In the event an interview is granted, the practitioner shall be informed of the general nature of the circumstance leading

to such recommendation and may present information relevant thereto. A record of the matters discussed and findings resulting from such interview shall be made.

## ARTICLE IX

### FAIR HEARINGS AND APPELLATE REVIEWS

#### Article IX, Section 1

##### Review Philosophy

The Medical Staff, the Board of Directors, and their officers, committees, and agents hereby constitute themselves as peer review bodies under the Federal Health Care Quality Improvement Act of 1986 and State Peer Review Act and claim all privileges and immunities afforded by the federal and state laws.

#### Article IX, Section 2

##### Definitions

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Section:

- A. "Body whose decision prompted the hearing" refers to the Executive Committee in all cases where the Executive Committee or authorized Medical Staff officers, members or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Board in all cases where the Board or authorized officers, directors or committees of the Board took the action or rendered the decision which resulted in a hearing being requested.
- B. "Practitioner" refers to the practitioner who has requested a hearing pursuant to Section 5 of this Article.
- C. "Date of Receipt" of any notice or other communication shall be deemed to be the date it was delivered personally to the addressee or, if delivered by regular or certified mail, three (3) working days after it was deposited, postage prepaid, in the United States mail.

#### Article IX, Section 3

##### Substantial Compliance

Technical or insignificant deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

#### Article IX, Section 4

##### Grounds for Hearing

Any one or more of the following actions or recommended actions shall constitute grounds for a hearing as long as such action or recommendation is based on the competence or professional conduct of the practitioner:

- A. Denial of Medical Staff membership.

- B. Denial of Medical Staff reappointment.
- C. Suspension of Medical Staff membership for more than fourteen (14) calendar days until completion of specific conditions or requirements.
- D. Summary suspension of Medical Staff membership for more than fourteen (14) calendar days during the pendency of corrective action and hearing and appeals procedures.
- E. Expulsion from Medical Staff membership.
- F. Denial of requested privileges.
- G. Reduction in privileges.
- H. Suspension of privileges for more than fourteen (14) calendar days until completion of specific conditions or requirements.
- I. Summary suspension of privileges for more than fourteen (14) calendar days during the pendency of corrective action and hearing and appeals procedures.
- J. Termination of clinical privileges.
- K. Requirement for pre-treatment consultation or proctoring.

Recommendation of any of these actions shall constitute an "adverse recommendation" for the purposes of these Bylaws.

Denial of Medical Staff membership, denial of medical reappointment, or revocation of Medical Staff membership for a physician's failure to meet a basic qualification, including board eligibility/board certification requirement, shall not constitute grounds for a hearing. If a practitioner holds privileges in more than one specialty, only the clinical privileges in the affected specialty shall be terminated in the event of noncompliance with Article III, Section 2 and the physician's membership and other clinical privileges shall not be affected.

#### Article IX, Section 5

##### Requests for a Hearing

- A. Notice of Action or Proposed Action. Whenever any of the actions constituting grounds for hearing as set forth in Article IX, Section 4 has been recommended, the Chief of Staff and/or the President/CEO shall give the affected practitioner notice in writing of the recommendation and notice of his/her right to request a hearing pursuant to Section 5 B., below. The notice should state:
  - 1. What corrective action has been proposed against the practitioner;
  - 2. The reason for the proposed action;
  - 3. That a hearing must be requested within thirty (30) days; and
  - 4. That the practitioner has the hearing rights described in these Bylaws.

- B. Request for Hearing. The practitioner shall have thirty (30) days following the date of receipt of a notice of an adverse action to request a hearing by a Judicial Hearing Committee. Said request must be submitted in writing to the Chief of Staff and the President/CEO. If the practitioner does not request a hearing within the time and in the manner herein above set forth, he/she shall be deemed to have accepted the recommendation, decision, or action involved and it shall thereupon become the final action of the Medical Executive Staff, subject to approval by the Governing Body.
- C. Time and Place for Hearing. Upon receiving a request for hearing, the Chief of Staff and/or the President/CEO, within thirty-five (35) days after he/she receives the request, shall schedule and arrange for a hearing. He/she shall give notice to the petitioner of the time, place, and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days, nor more than ninety (90) days from the date the request for a hearing was received; provided, however, that when the request is received from a practitioner who has been summarily suspended, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days after the hearing request was received.
- D. Notice of Charges and Witnesses. As a part of, or together with the notice of hearing required by Section 5 C. above, the Chief of Staff shall state in writing the acts or omissions with which the practitioner is charged. He shall include a list of any charts being questioned or the grounds upon which the application was denied, where applicable.

Each party, at least ten (10) working days prior to the hearing, shall furnish to the other a written list of the names and addresses of the individuals, so far as is then actually anticipated, who will give testimony or evidence in support of that party at the hearing. The witness list shall be amended when additional witnesses are identified.

- E. Hearing Committee. The Chief of Staff and the President/CEO shall appoint a Hearing Committee consisting of at least three (3) members of the Medical Staff, and alternates as appropriate who are acceptable to both the Hospital and the individual practitioner involved. The hearing panel members shall not have actively participated in the formal consideration of the matter at any previous level and not have an economic interest in and/or a conflict of interest with the subject of the Peer Review activity. Impartial peer would also exclude individuals with blood relationships, employer/employee relationships or other potential conflicts that might prevent the individual from giving an impartial assessment, or give the appearance for the potential of bias for or against the subject of the Peer Review. The Chief of Staff or the President/CEO shall designate a Chairman who shall preside in the manner described in Section 6 C. below, and handle all pre-hearing matters and preside until a hearing officer, as described in Section 6 D. below, is appointed.
- F. Failure to Appear. Failure without good cause of the practitioner to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and it shall thereupon become the final recommendation of the Medical Executive Staff, subject to approval by the Governing Body.
- G. Postponements and Extensions. Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by any affected person and shall be permitted by the Hearing Committee or its Chairman acting upon its behalf on a showing of good cause.

Article IX, Section 6

Hearing Procedure

- A. Pre-hearing Procedure. It shall be the duty of practitioner and the Executive Committee to exercise reasonable diligence in notifying the Hearing Committee or its Chairman of any pending or anticipated procedural irregularity, as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may expeditiously be made.

The Hearing Committee or its Chairman shall encourage the parties to exchange documents prior to the hearing and may require advance disclosure and limit introduction of any documents not provided to the other side in a timely manner.

- B. Representation. The practitioner shall be entitled to be accompanied by and represented at such hearings by an attorney or other representative of his or her choice. The body whose decision prompted the hearing may be represented by an attorney or appoint a representative from the Medical Staff or from the Board who shall present its recommendation, decision, or action taken and the materials in support thereof and examine witnesses.
- C. The Presiding Officer. The presiding officer at the hearing shall be a hearing officer as described in Section 6 D. or, if no such hearing officer has been appointed, the Chairman of the Hearing Committee. The presiding officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. He/she shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing. He/she shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure, or the admissibility of evidence.
- D. The Hearing Officer. At the request of the practitioner, the Executive Committee, the Hearing Committee, or the Board, the President/CEO may appoint a hearing officer to preside at the hearing. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing and, preferably, with experience in Medical Staff matters. He/she shall not be biased for or against the practitioner. He/she may participate in the deliberations and be a legal advisor to it, but he/she shall not be entitled to vote.
- E. Record of the Hearing. The Hearing Committee shall maintain a record of the hearing by using a qualified reporter to record the hearing or by tape recording the proceedings. The practitioner shall be entitled to receive a copy of the transcript or recording upon paying the cost of preparing a copy.
- F. Rights of the Parties. At the hearing both sides shall have the following rights: (i) to call and examine witnesses, (ii) to introduce exhibits or other documents, (iii) to cross-examine or otherwise attempt to impeach any witness who testified orally on any matter relevant to the issues, and (iv) to otherwise rebut any evidence. The practitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination. Each party has the right to submit a written statement in support of his/her position and the Hearing Committee may request such a statement to be filed following the conclusion of the presentation of oral testimony.

- G. Miscellaneous Rules. The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the presiding officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.
- H. Basis of Decision. If the Hearing Committee should find the charge(s) or any of them to be true, it shall recommend such form of discipline as it finds warranted. The decision of the Hearing Committee shall be based on the evidence produced at the hearing. Such evidence may consist of the following:
1. Oral testimony of witnesses.
  2. Briefs or written statements presented in connection with the hearing.
  3. Any material contained in the Hospital or Medical Staff personnel files regarding the practitioner, which shall have been made a part of the hearing record.
  4. Any and all applications, references, medical records, exhibits and other documents and records which shall have been made a part of the hearing record.
  5. Any other evidence admissible hereunder.
- I. Burden of Going Forward and Burden of Proof. The practitioner shall bear the ultimate burden of persuading the Hearing Committee, by a preponderance of the evidence provided at the hearing, that the reasons for the decision, as set forth in the notice of charges and presented at the hearing, lacked any factual basis or that the recommended action or decision was otherwise arbitrary or unreasonable.
- J. Adjournment and Conclusion. The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The Hearing Committee shall thereupon, outside of the presence of the parties, conduct its deliberations and render a decision and accompanying report. Final adjournment shall not occur until the Hearing Committee has completed its deliberations.
- K. Decision of the Hearing Committee. Within fifteen (15) days after final adjournment of the hearing (provided that in the event the practitioner is currently under suspension, this time shall be ten (10) working days), the Hearing Committee shall render a decision which shall be accompanied by a written report that contains findings of fact, which shall be in sufficient detail to enable the parties, any appellate review board, and the Board to determine the basis for the Hearing Committee's decision on each matter contained in the notice of charges. The decision and report shall be delivered to the Executive Committee, the President/CEO and the Board. At the same time, a copy of the report and decision shall be delivered to the practitioner by registered or certified mail, return receipt requested. The decision of the Hearing Committee shall be considered final, subject only to the approval of the Governing Body and the right of review by or appeal to the Board as provided in Article IX, Section 7.

Article IX, Section 7

Appeals to the Governing Body

- A. Time for Appeal. Within thirty (30) days after the date of receipt of the Hearing Committee's decision, either the practitioner, the body whose decision prompted the hearing, or the Board (on its own motion) may request an appellate review by the Board. Said request shall be delivered to the President/CEO in writing either in person, or by certified or registered mail, return receipt requested, and it shall briefly state the reasons for the appeal. If appellate review is not requested within this period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Executive Staff, subject to approval by the Board.
- B. Reasons for Appeal. The reasons for appeal by either the practitioner or the Medical Executive Committee from the hearing shall be: (a) substantial failure of any person to comply with the procedures required by these Bylaws or applicable law in the conduct of the hearing and the rendering of the decision so as to deny practitioner a fair hearing; (b) the lack of substantive rationality of a Medical Staff bylaw relied upon by the Hearing Committee in reaching its decision; and/or (c) action taken arbitrarily, unreasonably, or capriciously.
- C. Time, Place and Notice. When appellate review is requested pursuant to the preceding subsection, the Board shall, within thirty (30) days after the date of receipt of such an appeal notice, schedule and arrange for an appellate review. The Board shall give the practitioner notice of the time, place, and date of the appellate review. The date of appellate review shall be not less than fifteen (15) nor more than ninety (90) days from the date of receipt of the request for appellate review. If, however, a practitioner is under suspension, the appellate review shall be held as soon as the arrangements may reasonably be made, but not more than forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause by the Board, or appeal board (if any).
- D. Appeal Board. When an appellate review is requested, the Board may sit as the appeal board or it may appoint an appeal board which shall be composed of Board members and shall have at least three (3) members. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter.
- E. Hearing Procedure. The proceedings by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the Hearing Committee. The appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Hearing Committee hearing; or the appeal board may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party has the right to present a written statement in support of his/her position on appeal and, in its sole discretion, the appeal board may allow each party or representative to personally appear and present oral arguments. At the conclusion of oral argument, if allowed, the appeal board may thereupon conduct, at a convenient time, deliberations outside the presence of the parties and their representatives.

If an appeal board is appointed, the appeal board shall present to the Board its written recommendations as to whether the Board should affirm, modify, or reverse the Hearing

Committee's decision, or remand the matter to the Hearing Committee for further review and decision. If no appeal board is appointed, the procedures outlined in this subsection shall apply to a hearing before the Board.

- F. Decision. Within fifteen (15) days after adjournment of the appellate review proceedings, the Board shall render a final decision in writing. Final adjournment shall not occur until the Board has completed its deliberations. The Board may affirm, modify, or reverse the Hearing Committee's decision, or, in its discretion, remand the matter for further review and recommendation by the Hearing Committee or any other body or person. Copies of the decision shall be delivered to the practitioner and to the Executive Committee, by personal delivery or by mail.
- G. Further Review. Except when the matter is remanded for further review and recommendation, the final decision of the Board following the appeal procedures set forth in this Article shall be effective immediately and shall not be subject to further review. If the matter is remanded to the Hearing Committee or any other body or person, said committee, body, or person shall promptly conduct its review and make its recommendations to the Board in accordance with the instructions given by the Board. The time for a further review and report shall not exceed ninety (90) days except as the parties may otherwise stipulate.
- H. Right to One Hearing. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one judicial, evidentiary hearing and one appellate review on any matter which shall have been the subject of action by either the Executive Committee or the Board or by both.
- I. Number of Hearings and Reviews. Notwithstanding any other provision of these, no practitioner is entitled as a right to request more than one evidentiary hearing and not more than one appellate review with respect to the subject matter that is the basis of the adverse action triggering the right to such hearing and appellate review.
- J. Release. By requesting a hearing or appellate review, a practitioner agrees to be bound by the provisions of these Bylaws relating to immunity from liability.
- K. Substantial Compliance. Strict compliance with procedures and timelines set forth in these Bylaws is not required. The Hospital and Medical Staff shall make good faith efforts to substantially comply with the procedures and timelines set forth herein.
- L. Exhaustion of Legal Remedies. Any applicant or practitioner entitled to a hearing and appellate review must follow and exhaust the procedures and remedies afforded by these Bylaws as a prerequisite to any other legal action, if any, available to the applicant or practitioner.
- M. Confidentiality. All records, communications, determinations and other information and materials generated in connection with and/or as a result of the Hospital's peer review activities shall be confidential and privileged, and each individual or peer review committee member participating in such review activities shall agree to make no disclosures of any such information except as authorized in writing, by the Chairperson or Vice-chairperson of the applicable peer review committee. Any breach of confidentiality by an individual or peer review committee member may result in the loss of federal and/or state immunity afforded to such proceedings and/or a professional review action, and/or may result in appropriate legal action to ensure that confidentiality is preserved, including application to a court of law for injunctive or other relief.

- N. Peer Review Protections. All minutes, reports, recommendations, communications, determinations, and actions made or taken pursuant to these Bylaws are deemed to be covered by the Indiana Peer Review Act IC-34-30-15 et seq. or the corresponding provisions of any subsequent federal or state statute providing immunity and privileges to peer review or related activities. Furthermore, the peer review committees charged with making reports, findings, recommendations, determinations or investigations pursuant to these Bylaws shall be considered to be acting on behalf of the Hospital and the Board when engaged in such Professional Review Activities and therefore shall be deemed to be professional review bodies as that term is defined in the Health Care Quality Improvement Act of 1986.

Article IX, Section 8

Governing Body Authority

The Board of Directors is the supreme authority in the Hospital in accordance with Indiana law. The Board shall have the responsibility of hearing appeals of the decisions of the Hearing Committee following its hearings, and the decisions of the Board thereon shall be final.

Article IX, Section 9

Reports

Any reports of any final adverse action which may be required under State or Federal law shall be made promptly by the President/CEO.

Article IX, Section 10

Allied Health Professionals

Allied Health Professionals are not entitled to the fair hearing rights set forth in this Section (See Article V, Section 8 J).

ARTICLE X

OFFICERS, SERVICE CHIEFS AND DIRECTORS OF THE MEDICAL STAFF

Article X, Section 1

A. Officers of the Medical Staff

The officers of the Medical Staff shall be the President, Vice-President and Secretary. Officers must be members of the Active Medical Staff at the time of election and must remain members during their term of office. Failure of any officer to maintain such status shall be immediate cause for that person to vacate his or her office.

1. President and Chief of Staff. The President shall preside as Chairperson of the Medical Executive Committee and the General Medical Staff Committee and shall be an ex-officio member of all staff committees. He or she shall also serve as Chief Officer of the Medical Staff and be responsible for the function of the Medical Staff and general supervision of the clinical work done in the Hospital. He or she shall, in collaboration with the President/CEO or designee, appoint the medical directors and members to the

Medical Staff committees. He or she shall be the designated spokesperson for the Medical Staff in external professional and public relations and perform other functions as may be assigned by these Bylaws, Medical Staff or the Medical Executive Committee. He or she represents the views and policies of the Medical Staff to the Board of Directors.

2. Vice President and Vice Chief of Staff. The Vice-President shall assume all duties and have the authority of the President in his or her absence. He or she shall also be expected to perform such duties of supervision as may be assigned to him or her by the President. The Vice-President shall automatically succeed the President when the latter fails to serve for any reason.
3. Secretary. The Secretary shall keep minutes of meetings of the General Medical Staff and the Executive Committee, call meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to the office.

B. Service Chiefs

The Medicine, Family Practice, Surgery, Obstetric, Pediatric and Outpatient Medical Services shall each have a Chief who is a member of the Active Medical Staff and qualified by training, experience and demonstrated ability for the position. Each Chief shall:

1. Be accountable for professional, educational and administrative activities within the service;
2. Give guidance on the overall medical policies of the Hospital and make specific recommendations and suggestions regarding his or her service in order to assure quality patient care;
3. Be responsible for implementation of actions taken by the Executive Committee and for enforcement of the Bylaws within the service;
4. Make recommendations concerning staff appointment and reappointment, categorization and delineation of clinical privileges, and perform continuing review of professional performance of all practitioners with clinical privileges in his or her service; and
5. Conduct meetings involving all members and practitioners holding privileges in the service as is necessary to address problems, policy or other issues pertaining to the service.

C. Elections of Officers and Service Chiefs of the Medical Staff

1. Officers of the Medical Staff, Service Chiefs and an at-large member of the Executive Committee shall be elected on the even years to serve a two-year term, at the November meeting by a majority vote of those members of the Active Medical Staff eligible to vote.
  - i. A slate of officers will be prepared in advance by the Executive Committee of the Medical Staff.
  - ii. All nominees shall be contacted regarding their willingness to serve.

- iii. The slate of officers shall be communicated, in advance of the election, to the Active Medical Staff members.
  - iv. The Executive Committee of the Medical Staff will submit the slate of officers at the November meeting on the even years following which nominations may be made from the floor.
- 2. The ballots shall be written and proxies shall be accepted.
  - 3. The candidate for each office / service receiving the majority of votes for that office / service shall be thereby elected to that office. In the event there are three or more nominees for an office / service and no nominee receives a majority, the name of the nominee receiving the fewest votes is omitted from each successive ballot until one candidate obtains a majority.

D. Term of Office

- 1. All officers / chiefs shall serve for a period of two years or until a successor is elected.
- 2. All officers / chiefs shall take office on the first day of the calendar year following elections.

E. Resignation and Recall from Office

- 1. Any officer / chief may resign at any time by giving written notice to the Executive Committee of the Medical Staff.
- 2. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified in it.
- 3. Recall of an office holder during his or her term of office may be initiated by the Medical Executive Committee or by a petition signed by at least one-third of the members of the Medical Staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require two-thirds vote, by secret ballot, of the Medical Staff members who are present and eligible to vote for Medical Staff Officers. Permissible basis for recall of a Medical Staff Officer may include but may not be limited to:
  - i. Failure to perform the duties of the position held in a timely and appropriate manner.
  - ii. Failure to continuously satisfy the qualifications for the position.
  - iii. Conduct or statements unfavorable or damaging to the best interests of the Hospital or Medical Staff or to their goals, programs or public image.
  - iv. Having a conflict of interest with the Hospital.
  - v. Physical or mental infirmity that renders the staff member incapable of fulfilling his/her duties.

F. Vacancies in Office

1. Vacancies in office during the staff year, except for the Chief of Staff, shall be filled by an election at the next staff meeting.
2. If there is a vacancy in the Office of the Chief, the Vice Chief of Staff shall serve out the remaining term, and the staff shall elect a new Vice Chief of Staff.

Article X, Section 2

Directors

Anesthesia, Emergency, Pathology and Radiology Services shall each have a Director who is a member of the Active Medical Staff and is qualified by training, experience and demonstrated ability for the position. The Service Directors are appointed annually, and may serve unlimited number of terms, by the President/CEO in collaboration with the Chief of Staff. The Service Directors perform the same functions as the Service Chiefs, as listed above in Section 1 B (1-5) of this Article. Resignations and vacancies are addressed by the President/CEO in collaboration with the Chief of Staff.

ARTICLE XI

STRUCTURE OF THE MEDICAL STAFF

Article XI, Section 1

Non-Departmental Organization

Due to its size and functions, the Medical Staff is organized on a non-departmental basis.

Article XI, Section 2

Clinical Services

A. General

1. Service Assignment. Each Medical Staff member shall make application for and be assigned clinical privileges in one or more of the following services: Medicine, Family Practice, Surgery, Obstetrics, Pediatrics, Emergency, Radiology, Pathology and Anesthesia. Professional Staff Practitioners, Allied Health Professionals and Auxiliary Physicians shall be assigned to clinical services as specified in Article V Sections 2-8 of these Bylaws.
2. Bylaws, Policies and Procedures. Upon assignment to a clinical service, the practitioner agrees to comply with the Bylaws, and policies and procedures of the Medical Staff and the Hospital pertaining to that service.

B. Services. The Medical Staff shall assign all members to and shall monitor and evaluate the following clinical services.

1. Medicine (Internal Medicine)
2. Family Practice

3. Surgery
4. Obstetrics
5. Pediatrics
6. Emergency
7. Radiology
8. Pathology
9. Anesthesia

C. Emergency Call. The Medical Staff will maintain an emergency on-call system (refer to Medical Staff Emergency On-Call policy).

1. Responsibility. All members of the Active Medical Staff, and other professionals designated by the Medical Staff, will be responsible to take their turn at emergency on-call service unless the physician is over age 65 or otherwise specifically exempted by the Medical Staff.
2. Availability. The on-call physician shall be available to reasonably respond to requests of the Hospital for assistance. If the physician is unable to perform on-call service, he or she will be responsible to provide a qualified replacement in accordance with 42 U.S.C. Section 1395dd, as amended, commonly referred to as the Anti-Dumping Statute.

D. Surgery Service.

1. Scheduling. Surgical scheduling will be done in accordance with approved Hospital and Medical Staff policies.
2. History and Physical Examination. For all surgery patients (inpatient, outpatient and ambulatory care patients), a written history and physical examination must be completed and in the patient record before an operation is performed, unless the attending physician states, in writing, that such delay would constitute a hazard to the patient.
3. Consent. An operation shall be performed only with an informed consent of the patient or his or her legal representative, except in emergencies.
4. Tissues. All tissues removed during an operation shall have macroscopic and microscopic examinations performed, except those exempted by the Surgical Tissue Exempt List (SPP NO: NS-19). Physicians will perform the macroscopic examination of the specimens removed during surgical procedures which are exempted from microscopic examination.
5. Surgical Assistants. The operating surgeon shall have a qualified assistant at all major operations.
  - i. A qualified assistant is defined as a Physician, Dentist, Podiatrist, Nurse, Physician Assistant, or Surgical Technician. A qualified assistant who is a Hospital employee shall have similar qualifications.
  - ii. A qualified physician shall serve as assistant when Cesarean sections are performed, at the discretion of the surgeon, or when any other surgical procedures are performed which present, in the judgment of the surgeon, an unusual hazard to the life and limb of the patient.

- iii. A qualified non-physician shall serve as an assistant at the discretion of the surgeon when surgical procedures such as: open abdominal cases, laparoscopic cases, and orthopedic joint replacements are performed. No assistant other than the scrub and circulator are required on cases such as: ENT, ophthalmic, endoscopic and simple skin/subcutaneous.
- iv. It is the responsibility of the operating surgeon to arrange for a qualified assistant.

E. Obstetrics Service – Infant Testing

All newborn infants receive screening tests as required by law.

F. Emergency Service – Disaster/Mass Casualty Situations

All physicians shall be assigned to posts, either in the Hospital, or in a mobile casualty station, in accordance with the Hospital disaster plan. The Chief of Staff and the President/CEO, or their designees, will work as a team to coordinate activities and directions during a mass casualty situation. All physicians on the Medical Staff will relinquish directions of the professional care of their patients to the Chief of Staff or his or her designee in cases of such an emergency.

G. Radiology Service – Radiation Safety Officer

The Hospital shall assure that a physician is appointed to serve as Radiation Safety Officer. (S)He, or his or her designee, shall have the authority to take corrective action when needed to enforce the Hospital policies and procedures pertaining to radiation safety without getting the approval of the Medical Staff or President/CEO.

## ARTICLE XII

### GENERAL MEDICAL STAFF

#### Article XII, Section 1

##### Medical Staff Meetings

- A. Regular Meetings. The Medical Staff will hold meetings every other month, when possible, at the Hospital. Discussion at these meetings shall include reports of various committees and the status of the medical care, including review and analysis of clinical work done in the Hospital.
- B. Annual Meeting. An annual General Medical Staff meeting shall be held in November. Every other year on even number years, the election of officers will be conducted at the annual meeting.
- C. Voting Rights. All Active Medical Staff members have equal voting rights, with one vote per member.
- D. Quorum. For the purpose of conducting business at the General Medical Staff meetings, fifty percent of the total voting membership of the Active Medical Staff, absentee ballots to be included, shall constitute a quorum.

- E. Special Meetings. Special meetings of the Medical Staff may be called at any time by the President/CEO or any five (5) members of the Active Medical Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting, which shall be distributed in writing at least forty-eight (48) hours before the time set for the meeting.
- F. Minutes. Reports of the all General Medical Staff meetings shall be kept and copies of the reports maintained in Administration/Medical Staff Office. After approval by the General Medical Staff, the minutes will be signed by the Medical Staff secretary.

Article XII, Section 2

Meeting Attendance Requirements

- A. Active Medical Staff members are required to attend at least one (1) of the regular staff meetings in any calendar year. Failure to comply with this provision shall be considered during the reappointment process.
- B. Members of the Affiliate Staff, Honorary Staff and Specified Professional Practitioners are not required to attend meetings but are encouraged to participate.

ARTICLE XIII

COMMITTEES OF THE MEDICAL STAFF

The primary purpose of staff meetings is to conduct business relating to the improvement in the care and treatment of patients at the Hospital.

Article XIII, Section 1

General Information

- A. Members of each committee, except the Executive Committee, shall be appointed annually by the President/Chief of Staff in collaboration with the Hospital President/CEO or designee. All Medical Staff Committees shall have a majority of physician members and shall act in accordance with the Indiana Peer Review Act and the Federal Health Care Quality Improvement Act when reviewing the professional competency or conduct of Medical Staff Members. All appointed committee members shall have a vote, regardless of Medical Staff status. All appointed members may be removed, and the vacancies filled, by the President/Chief of Staff and in collaboration with the President/CEO or designee.
- B. Standing Committees are identified in this section. The President/Chief of Staff may appoint other committees as needed. Such committees shall confine their activities to the purpose for which they were appointed and shall report to the Executive Committee.
- C. The presence of fifty percent (50%) of the total voting membership of the Standing Committees shall constitute a quorum. Proxy votes are permitted at all Standing Committee meetings, excluding the Medical Executive Committee meetings.
- D. A consensus of fifty percent (50%) of the total voting membership is required to pass a vote at all Standing Committee meetings.

Article XIII, Section 2

Executive Committee

- A. Members of the Executive Committee must be doctors of medicine or osteopathy, shall be elected by the Medical Staff and shall consist of the Officers of the Medical Staff, Chiefs of Service and the Immediate Past Chief of Staff, or an at-large-member if the Past Chief of Staff is unable to serve. The Past Chief of Staff shall generally represent the Anesthesia, Emergency, Pathology and Radiology Services. The Chief of Staff shall serve as chairman of the committee. The President/CEO shall be an ex-officio member without vote.
- B. The duties of the Executive Committee shall be to:
1. Represent and act on behalf of the Medical Staff in all matters between regular meetings of the Medical Staff, subject only to limitations imposed by the Bylaws;
  2. Receive and act upon the reports and recommendations of Medical Staff Committees, Service Chiefs or Directors and assigned activity groups;
  3. Implement the approved policies of the Medical Staff;
  4. Perform the credentials function and make recommendations to the Medical Staff and Board on matters relating to appointments and reappointments, staff categorization, service assignments, clinical privileges, and professional standards in accordance with the Medical Staff Bylaws;
  5. Pursue any investigations and actions and conduct hearings in accordance with Medical Staff Bylaws;
  6. Assure that a regular review and evaluation of the quality and appropriateness of patient care rendered within the Hospital is carried out through designated mechanisms;
  7. Receive and act upon peer review matters including mortality review;
  8. Recommend source(s) for services not available at the facility;
  9. Recommend action to the President/CEO on matters of a medical-administrative nature;
  10. Insure that the Medical Staff is kept abreast of the standards and requirements of licensing and accrediting organizations; and
  11. Account to the Board for the quality of the overall medical care rendered to patients in the Hospital.
  12. Shall review bi-annually the Medical Staff Bylaws to assure compliance with the requirements of applicable accrediting and licensing bodies and to make recommendations for changes or amendments thereto to the Medical Staff.
  13. The Executive Committee shall prepare a slate of candidates for the bi-annual election of officers of the Medical Staff.

- C. The Executive Committee shall meet monthly, if needed. A record of all proceedings and actions of the Executive Committee will be maintained by the Medical Staff Secretary. The Executive Committee shall provide a report of its actions periodically to the Medical Staff.
- D. The Executive Committee members are expected to attend at least fifty percent (50%) of the meetings in any calendar year.

Article XIII, Section 3

Medical Care Evaluation Committee

- A. The Medical Care Evaluation Committee shall consist of at least three (3) members of the Active Medical Staff. A representative from the Nursing Service Division shall be an ex-officio member with vote. The Health Information Manager, the Adult Medical Unit Manager and a representative from Case Management shall be ex-officio members without vote.
- B. The duties of the Committee shall be to:
  - 1. Work with the Health Information Department to assure that all medical records meet acceptable standards and criteria and are reviewed for timely completion, clinical pertinence and overall adequacy.
  - 2. The Committee shall conduct utilization management studies designed to assess the appropriateness of allocation of Hospital and physician services. The Committee shall have the authority to review all medical records of any hospitalization during the patient stay or after discharge.
  - 3. Review and evaluate the quality, safety and appropriateness of patient care services provided within the Adult Medical Unit. Initiate appropriate actions based upon findings of the review activities. The Committee shall also function as a forum to resolve problems and initiate and discuss policy issues related to the Adult Medical Unit.
  - 4. Review all cases reasonably assumed by the Hospital to be outlier cases because of the extended length of stay exceeding the threshold criteria for diagnosis.
  - 5. Serves as the Professional Medical Library Committee by recommending the acquisition, purchase, or discarding of educational materials.
- C. The Medical Care Evaluation Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings, and actions and shall submit a report thereof to the Executive Committee.
- D. The committee members from the Active Medical Staff are expected to attend at least fifty percent (50%) of the meetings in any calendar year.

Article XIII, Section 4

Infection Control Committee

- A. The Infection Control Committee shall consist of at least three (3) members of the Active Medical Staff, including the Pathology Service Director. Representatives of the Administration,

Nursing or their designee, and the Infection Preventionist shall be ex-officio members with vote. A Laboratory Representative shall be ex-officio members without vote.

- B. The duties of the Infection Control Committee shall be to:
1. Develop, review and enforce policies and procedures regarding employee health and a Hospital infection control program, including an infection surveillance and reporting program and standard criteria for reporting infection cases; and
  2. Function as a forum to resolve problems, initiate and discuss policy issues, and establish and review rules and regulations for the Laboratory.
  3. Establish policies and procedures governing all transfusions of blood of blood derivatives, systems for reporting transfusion reactions, and monitoring of appropriateness of blood transfusions.
  4. Develop policies and procedures regarding transfusions of potentially HIV/HCV infectious blood and blood products.
- C. The Infection Control Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall submit a report thereof to the Executive Committee.
- D. The committee members from the Active Medical Staff and the Pathology Service Director are expected to attend at least fifty percent (50%) of the meetings in any calendar year.

#### Article XII, Section 5

##### Pharmacy and Therapeutics Committee.

- A. The Pharmacy and Therapeutics Committee shall consist of at least four (4) members of the Active Medical Staff. One (1) representative each from Nursing Administration and Hospital Administration, and the Pharmacy Manager shall be ex-officio members with vote.
- B. The duties of the Pharmacy and Therapeutics Committee shall be to examine and survey all drug utilization policies and practices within the Hospital. The Committee shall assist in the development of professional policies and procedures regarding the evaluation, appraisal, selection, procurement, storage, distribution, handling and safe administration of drugs, as well as all other matters relating to drugs within the Hospital. The Committee also has the responsibility to:
1. Develop a drug formulary and review it and update it regularly;
  2. Advise the Medical Staff and the pharmacist on matters pertaining to the choice of available drugs and the addition or deletion of drugs from the Hospital formulary or drug list;
  3. Establish, maintain and support a mechanism for effective communication to the Medical Staff, Hospital personnel and patients as it pertains to general drug usage;

4. Establish, maintain and support a mechanism for safe-guarding the rights and welfare of human subjects involved in clinical investigations;
  5. Establish standards for the use and control of investigational drugs; and
  6. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
  7. Evaluate drug usage.
  8. Formulate procedures for reporting adverse drug reactions and medication errors/near misses in administration of drugs. Participate in the investigation, evaluation and implementation of the appropriate actions to correct identified problems, minimize medication errors and improve medication administration safety.
- C. The Pharmacy and Therapeutics Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions and shall submit a report thereof to the Executive Committee.
- D. The committee members from the Active Medical Staff are expected to attend at least fifty percent (50%) of the meetings in any calendar year.

#### Article XIII, Section 6

##### Critical Care Committee

- A. Critical Care Committee shall be composed of at least two (2) members of the Active Medical Staff and the Emergency Service Director. A representative from Hospital Administration shall be an ex-officio member with vote. The Emergency Department Manager and the Intensive Care Unit Manager shall be ex-officio members without vote.
- B. The duties of the Critical Care Committee shall be to:
1. Review and evaluate the quality, safety and appropriateness of patient care services provided within the Intensive Care Unit and Emergency Department. Initiate appropriate actions based upon findings of the review activities. The Committee shall also function as a forum to resolve problems and initiate and discuss policy issues related to the Intensive Care Unit and Emergency Room Department.
  2. Develop and maintain current standardized policies and procedures for medical control and direction of an Advanced Life Support emergency ambulance service.
  3. The Critical Care Committee shall meet at least quarterly and shall maintain a permanent record of its findings, proceedings and actions and shall submit a report thereof to the Executive Committee.
- C. The committee members from the Active Medical Staff and the Emergency Service Director are expected to attend at least fifty percent (50%) of the Critical Care Committee meetings in any calendar year.

Article XIII, Section 7

Radiation Safety

- A. The Radiation Safety Committee shall consist of at least three (3) members of the Active Medical Staff, including the Radiology Service Director. A representative from Hospital Administration and the Radiology Department Manager shall be ex-officio members with vote. A Radiology Department Nurse shall be an ex-officio member without vote.
- B. The Committee shall function as a forum to resolve problems, initiate and discuss policy issues and establish and review rules and regulations for Radiology services.
- C. The Committee shall meet at least annually, shall maintain a permanent record of its findings, proceedings and actions, and shall submit a report thereof to the Executive Committee.

Article XIII, Section 8

Pediatric Committee

- A. Pediatric Committee shall be comprised of at least two (2) members of the Active Medical Staff whose practice includes the care of infants and children and the Chief of Pediatrics. A representative from Nursing Administration and the Pediatric Manager shall be ex-officio members with vote.
- B. The duties of the Pediatric Committee shall be to:
  - 1. Review and evaluate the quality, safety and appropriateness of patient care services provided to infants and children at Major Hospital. Initiate appropriate actions based upon findings of the review activities. The Committee shall also function as a forum to resolve problems, initiate and discuss policy issues related to the care of infants and children throughout the Hospital.
  - 2. Develop and maintain current standardized policies and procedures for medical control and direction of Pediatric and Neonatal Advanced Life Support / Neonatal Resuscitation Program.
  - 3. The Pediatric Committee shall meet at least quarterly and shall maintain a permanent record of its findings, proceedings and actions and shall submit a report thereof to the Executive Committee.
- C. The committee members from the Active Medical Staff and Emergency Services are expected to attend at least 50% of the Pediatric Committee meetings in any calendar year.

Article XIII, Section 9

OB Section Committee

- A. OB Section Committee shall be composed of at least two (2) members of the Active Medical Staff, including one member from Anesthesia services and the Chief of OB. A representative from Nursing Administration shall be an ex-officio member with vote. The OB Manager shall be an ex-officio member without vote.

- B. The duties of the OB Section Committee shall be to:
1. Review and evaluate the quality, safety and appropriateness of patient care services provided to OB patients at Major Hospital. Initiate appropriate actions based upon findings of the review activities. The Committee shall also function as a forum to resolve problems, initiate and discuss policy issues related to the care of OB patients.
  2. The OB Committee shall meet at least quarterly and shall maintain a permanent record of its findings, proceedings and actions and shall submit a report thereof to the Executive Committee.
- C. The committee members from the Active Medical Staff are expected to attend at least fifty percent (50%) of the meetings in any calendar year.

Article XIII, Section 10

Surgical Section Committee

- A. The Surgical Section Committee shall consist of at least two (2) Active Medical Staff, including one member from Anesthesia services and the Chief of Surgery. A representative from Nursing Administration shall be an ex-officio member with vote. The Surgery Manager an ex-officio member without vote.
- B. The duties of the Surgical Section Committee shall be to:
1. Review and evaluate the quality, safety and appropriateness of patient care services provided within the Surgery Department. Initiate appropriate actions based upon findings of the review activities. The Committee shall also function as a forum to resolve problems and initiate and discuss policy issues related to the Surgery Department.
  2. Shall review all tissues classified as either minimum pathology or no pathology to determine the appropriateness of performing the procedure.
  3. The Surgical Section Committee shall meet at least quarterly and shall maintain a permanent record of its findings, proceedings and actions and shall submit a report thereof to the Executive Committee.
- C. The committee members from the Active Medical Staff are expected to attend at least fifty percent (50%) of the Surgical Section Committee meetings in any calendar year.

Article XIII, Section 11

Outpatient Medical Services Committee

- A. The Outpatient Medical Services Committee shall consist of at least five members of the Active Staff whose primary practice is outpatient-based and the Chief of Outpatient Medical Services. Two (2) representatives from Administration and the Director of Physician Practices shall be ex-officio members with vote.

- B. The duties of the Outpatient Medical Services Committee shall be to:
1. Functions as a forum to address and resolve issues related to Hospital-owned outpatient practices.
  2. Review, evaluate and make recommendations regarding service line developments.
  3. As related to Major Health Partners, review, evaluate the quality, safety and appropriateness of patient care services provided patients at outpatient practices. Initiate appropriate actions based upon findings of the review activities.
- C. The Outpatient Medical Services Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions and shall submit a report thereof to the Executive Committee.
- D. The committee members from the Active Medical Staff are expected to attend at least fifty percent (50%) of the meetings in any calendar year.

#### Article XIII, Section 12

##### Cancer / Tumor Board Committee

- A. Established as of January 1, 2011, the Cancer / Tumor Board Committee shall be composed of at least six (6) members of the Medical Staff, including a Medical Oncologist, a Radiation Oncologist, Radiologist, Pathologist, Surgeon and Primary Care Provider. The Radiation Oncology Manager and the Medical Oncology Manager shall be ex-officio members with vote.
- B. The duties of the Cancer / Tumor Board Committee shall be to:
1. Provide case conferences on complicated unusual and other pertinent clinical cases. Make recommendations on the best diagnostic and therapeutic approaches for malignancies. Report on new trends in diagnosis and therapy of malignancy. Ensure that all malignant tumor cases admitted are reviewed and that an accurate diagnosis is made before treatment is instituted. Ensure that all malignancies are staged when applicable and staging is a part of the patient's medical record and is included in care discussions.
  2. Make recommendations to staff on new concepts and procedures in oncology. Recommend the process to be used in accumulating statistics of importance to the evaluation of tumor diagnosis and treatment and review those statistics on a routine basis.
  3. Develop, review and enforce policies regarding Medical Radiation Oncology.
  4. The Cancer / Tumor Board Committee shall meet at least four (4) times per year and maintain a permanent record of its findings, proceedings and actions and shall submit a report thereof to the Executive Committee.
- C. The committee members from the Active Medical Staff are expected to attend at least fifty percent (50%) of the meetings in any calendar year.

## ARTICLE XIV

### POLICIES AND PROCEDURES

The Medical Staff shall adopt such policies and procedures as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Board. These shall relate to the proper conduct of Medical Staff organization activities as well as embody the level of practice that is to be required of each practitioner in the Hospital. The policies and procedures of the Medical Staff shall be supportive of and congruent with the Medical Staff Bylaws.

## ARTICLE XV

### GENERAL PROVISIONS

#### Article XV, Section 1

##### Confidentiality of Information

Information with respect to any member, Professional Staff, or Allied Health Professional submitted, collected or prepared by any representative or agent of the Hospital or Medical Staff for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, or in determining that qualifications of a health care provider shall, to the fullest extent permitted by Federal and Indiana law, be confidential and shall not be disseminated to anyone other than a duly authorized Hospital or Medical Staff representative for official purposes nor be used in any way except as provided herein or except as otherwise required or permitted by Federal or Indiana law.

#### Article XV, Section 2

##### Immunity from Liability

By applying for membership or clinical privileges at the Hospital, each applicant agrees that no individual who is a member, agent, or employee of the Hospital, the Medical Staff, Hospital Administration or Board shall be liable for civil damages as a result of his or her acts, omissions, decisions or any other conduct of a Peer Review Committee or as a result of their participation on a Peer Review Committee or any other committee whose purpose, directly or indirectly, is performance improvement, quality assurance, credentialing, patient care, utilization review, or such similar purpose for improving patient care within the Hospital or for the purpose of professional discipline.

#### Article XV, Section 3

##### Indemnification

The Hospital shall indemnify any individual who was or is a party or is threatened to be made a party to any threatened, pending or completed action, lawsuit or proceeding, whether civil, criminal, administrative or investigative (other than an action by or in the right of the Hospital). This obligation to indemnify arises only where the individual is a party or is threatened to be a party by reason of the fact that he or she is or was a director, officer, employee or agent of the Hospital or Medical Staff, served as an agent or personnel of a Peer Review Committee and the claim, allegation, complaint, or charge is directly related to their participation and role on a Peer Review Committee or in a Professional Review Action. Such indemnification shall be for expenses (including attorneys' fees), judgments, fines and amounts, whether paid in settlement actually and reasonably incurred by him or her in connection with

such action, suit or proceeding if he or she acted in good faith and in a manner reasonably believed to be in or not opposed to the best interests of the Hospital. Notwithstanding the Hospital's foregoing obligation to indemnify, no indemnification shall be made with respect to any criminal action or proceeding unless the individual had no reasonable cause to believe his or her conduct was unlawful. Further, no individual shall be indemnified with respect to any claim, issue or matter in which such individual shall have been adjudged to be liable to the Hospital.

#### Article XV, Section 4

#### Bylaws not a Contract

These Bylaws shall not be deemed as a contract of any kind between the Board of Directors and the Medical Staff or any individual member thereof. Applications for, the conditions of and the duration of appointment to and members on the Medical Staff or the granting of clinical privileges as Professional Staff or Allied Health Professional shall not be deemed contractual in nature since the continuance of any such clinical privileges at the Hospital is based solely upon a practitioner's continued ability to justify the exercise of such clinical privileges and do not obligate the members, Professional Staff, or Allied Health Professionals to practice at the Hospital. The Board of Directors is obligated to use essential fairness in dealing with Medical Staff members, Professional Staff, or Allied Health Professionals and applicants for those positions and may fulfill that obligation by following the procedures specified in these Bylaws or any other procedures which are fair under the circumstances.

### ARTICLE XVI

#### AMENDMENTS

These Bylaws may be amended at any regular meeting, after previous written notice, by majority vote of the total membership of the Active Medical Staff eligible to vote. Such amendments shall be effective when approved by the Board of Directors, approval not to be unreasonably withheld.

ARTICLE XVII

ADOPTION

These Bylaws may be adopted at any meeting of the Active Medical Staff and shall replace any previous Bylaws and shall become effective when approved by the Board of Directors of the Hospital. They shall be effective when adopted and approved by the Board and the Medical Staff.

The Bylaws are to be reviewed and updated no less often than every two years to assure congruence with Medical Staff practice.

These Bylaws have been approved by the Medical Staff at the meeting held on the 13th day of July, 2010.

MEDICAL STAFF OF MAJOR HOSPITAL

BY: \_\_\_\_\_  
President

ATTEST:

\_\_\_\_\_  
Secretary

These Bylaws have been approved by the Board of Directors at its meeting held on the 26th day of July, 2010.

BOARD OF DIRECTORS OF MAJOR HOSPITAL

BY: \_\_\_\_\_  
Chairperson

ATTEST:

\_\_\_\_\_  
Secretary