

**DUPONT HOSPITAL  
FORT WAYNE, INDIANA**

**MEDICAL STAFF BYLAWS**

**REVIEWED/REVISED BY THE MEC**

**November 27, 2000  
September 10, 2001  
August 4, 2003  
November 7, 2005  
September 5, 2006  
September 10, 2007  
November 2, 2009**

**ADOPTED BY THE MEDICAL STAFF**

**October 18, 2001  
October 14, 2003  
October 27, 2005  
September 27, 2006  
October 25, 2007  
October 29, 2009**

**APPROVED BY THE BOARD**

**December 11, 2000  
September 19, 2001  
August 12, 2003  
November 8, 2005  
September 12, 2006  
September 9, 2007  
November 10, 2009**

**INDEX**

<b>DEFINITIONS</b>		5
<b>ARTICLE I</b>	<b>NAME</b>	8
<b>ARTICLE II</b>	<b>PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF</b>	
2.1	Purposes	8
2.2	Responsibilities	8
<b>ARTICLE III</b>	<b>MEDICAL STAFF MEMBERSHIP</b>	
3.1	General Qualifications	10
3.2	Conditions and Duration of Appointment	12
3.3	Contract Practitioners	15
<b>ARTICLE IV</b>	<b>MEDICAL STAFF CATEGORIES</b>	
4.1	Categories of the Medical Staff	15
4.2	Active Staff	15
4.3	Courtesy Staff	17
4.4	Consulting Staff	18
4.5	Honorary Staff	18
4.6	House Staff	19
4.7	Limitation of Prerogatives	19
<b>ARTICLE V</b>	<b>DELINEATION OF PRACTICE PRIVILEGES FOR PRACTITIONERS</b>	
5.1	Exercise of Privileges	19
5.2	Bases for Determination of Privileges	19
5.3	System and Procedure for Granting and Delineating Privileges	19
5.4	Special Conditions for Active Privileges	20
5.5	Emergency & Disaster Privileges	20
5.6	Temporary Privileges	21
<b>ARTICLE VI</b>	<b>STAFF OFFICERS AND COMMITTEES</b>	
6.1	General Officers of the Staff	22
6.2	Term of Office	23

6.3	Attainment of Office	23
6.4	Vacancies in Office	23
6.5	Eligibility for Reelection	24
6.6	Resignation and Removal from Office	24
6.7	Duties of Officers	24
6.8	Medical Staff Committees	25
<b>ARTICLE VII                    CLINICAL SERVICES</b>		
7.1	Designation	29
7.2	Requirements for Affiliation with Clinical Services	29
7.3	Functions of Clinical Services	30
<b>ARTICLE VIII                  OFFICERS OF CLINICAL SERVICES</b>		
8.1	Designation and Qualifications of Officers	31
8.2	Selection	32
8.3	Term of Office	32
8.4	Resignation and Removal of Clinical Service Officers	33
8.5	Vacancies	33
8.6	Responsibility and Authority of Officers	33
8.7	Reporting Responsibilities	34
<b>ARTICLE IX                    CORRECTIVE ACTION</b>		
9.1	Routine Corrective Action	35
9.2	Summary Suspension	35
9.3	Automatic Suspension	36
<b>ARTICLE X                    HEARING AND APPELLATE REVIEW PROCEDURE</b>		
10.1	General Provisions	36
10.2	Grounds for Hearing	37
10.3	Request for a Hearing	37
10.4	Hearing Procedures	38
10.5	Appeal	41

10.6	Exceptions to Hearing Rights	42	
<b>ARTICLE XI MEETINGS</b>			
11.1	Medical Staff Year	42	
11.2	Medical Staff Meetings	43	
11.3	Services and Committee Meetings	43	
11.4	Attendance Requirements	43	
<b>ARTICLE XII CONFIDENTIALITY, IMMUNITY AND RELEASES</b>			
12.1	Special Definitions	43	
12.2	Authorizations and Conditions	44	
12.3	Confidentiality of Information	44	
12.4	Immunity from Liability	44	
12.5	Activities and Information Covered	45	
5	12.6	Cumulative Effect	45
<b>ARTICLE XIII GENERAL PROVISIONS</b>			
13.1	Staff Rules and Regulations	46	
13.2	Clinical Service Policies	46	
13.3	Staff Dues	46	
13.4	Indemnification	46	
<b>ARTICLE XIV ADOPTION AND AMENDMENT</b>			
14.1	Medical Staff Authority and Responsibility	47	
14.2	Medical Staff Action	47	

## DEFINITIONS

**“ACTIVE STAFF”** means those Medical Staff members who have declared the Hospital one of their primary hospitals for the practice of medicine and other related hospital activities, and who have been recognized by the Medical Staff by formal review processes to be members in good standing clinically and in all other ways referred to in these Bylaws.

**“ADMINISTRATOR”** means the individual, or designee, appointed by the members of the LLC to act in their behalf in the overall management of the Hospital.

**“ADVERSE RECOMMENDATION”** or **“ADVERSE ACTION”** means any recommendation or action that would restrict or deny the privileges or membership of a practitioner. Such terms also include any recommendation or action that grants or recommends the granting of privileges or membership to a practitioner that are inferior to the privileges or membership status sought by such practitioner. An adverse recommendation and/or adverse action shall entitle the affected practitioner to the appellate review procedures provided for in these Bylaws. The expiration of privileges pursuant to these Bylaws or an exclusive provider agreement between the Hospital and a provider shall not constitute an adverse recommendation and/or adverse action and shall not entitle the affected practitioners to the appellate review procedures outlined hereunder.

**“ALLIED HEALTH PROFESSIONAL”** means any dependent practitioner who performs special examinations or treatments or renders other services under the direction and supervision of the member of the Medical Staff who employs and takes responsibility for him.

**“BOARD”** means the Board of Directors of Dupont Hospital, LLC.

**“CHAIR OF THE SERVICE”** means the member of the Medical Staff elected by the Active Staff members of that service.

**“CLINICAL SERVICE”** means an organizational unit of the Medical Staff, comprised of practitioners who have been granted membership in that service, which has a representative on the Medical Executive Committee.

**“CLINICAL SERVICE CREDENTIALS AND EDUCATION COORDINATOR”** means the member of the Medical Staff elected by the Active Staff members of that service as provided in these Bylaws.

**“CONFLICT RESOLUTION COMMITTEE”** means the committee charged with managing conflict among leadership groups and reports to the Medical Executive Committee and the Board of Directors.

**“CONSULTING STAFF”** means those practitioners who possess specialized skills needed at the Hospital for a specified project or on an occasional basis when requested by authorized Staff officials.

**“CONTRACT PRACTITIONER”** means a practitioner who is or will be providing professional medical services to the Hospital and/or its patients pursuant to a direct contract with the Hospital. Such a practitioner may or may not be an employee of the Hospital, but shall in either event be required to fulfill the requirements of the Staff category to which he/she is assigned.

**“CORRECTIVE ACTION”** means any action taken against a member of the Medical Staff by the Medical Executive Committee or the Board in response to conduct by such member which is detrimental to patient care, detrimental to the best interests of the Hospital, in violation of these Bylaws or any rule or regulation promulgated pursuant hereto or any law or regulation applicable to such member's practice.

**“COURTESY STAFF”** means those Medical Staff members who do not intend to use the Hospital as one of their primary hospitals for practicing medicine, but who upon occasion, because of their association with Active Staff members and/or place of practice, need access to the Hospital to accommodate their patients and colleagues.

**“CREDENTIALS COMMITTEE”** means that body consisting of (a) the Vice President of the Staff, who shall serve as Credentials Committee Chair; and (b) the Credentials and Educational Coordinator selected by each Clinical Service, which body shall be responsible for reviewing applications for appointment and reappointment to the Medical Staff, matters of membership or clinical privileges, and matters of corrective action, all pursuant to these Bylaws.

**“DAYS”**: Unless otherwise specified, any reference to number of days refers to calendar days.

**“EX OFFICIO”** means by virtue of an office or position held. Unless otherwise expressly provided, an *ex officio* committee member shall have full voting rights.

**“HEARING”** means the peer review hearing process required by these Bylaws and defined in Article X hereof.

**“HONORARY STAFF”** means those former Medical Staff members who have retired from the Medical Staff and whom the Staff wishes to honor in recognition of their service to the Hospital or other noteworthy contributions to its activities, and other practitioners of outstanding professional attainment. Unless otherwise specified, Honorary Staff members shall neither enjoy the privileges, prerogatives or rights nor be subject to the qualifications, obligations or requirements otherwise applicable to Medical Staff members.

**“HOUSE STAFF”** means those practitioners-in-training resident at the Hospital and medical students who have provided proper credentials to the Credentials Committee. Unless otherwise specified, House Staff members shall not enjoy any of the privileges, prerogatives or rights otherwise applicable to Medical Staff members.

**“HOSPITAL”** means Dupont Hospital.

**“MEDICAL EXECUTIVE COMMITTEE”** means the Executive Committee of the Medical Staff. The Medical Executive Committee shall be comprised of the President (who shall Chair the Committee); the Vice President; the Secretary/Treasurer, the Chair of the Quality Committee; and the Chair, Vice Chair and the credentials education coordinator for each Clinical Service. The Medical Executive Committee is empowered to act for the Medical Staff as a whole in all matters except as noted in these Bylaws.

**“MEDICAL STAFF”** means all practitioners who are privileged to attend patients in the Hospital.

**“PERSONNEL OF A PEER REVIEW COMMITTEE”** means not only members of such committee but also all of the committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves on a peer review committee in any capacity whether such person is acting as a member or is under a contract or other formal agreement with the committee, and any person who participates with or assists the committee with respect to its actions.

**“PRACTITIONER”** means a doctor of medicine, doctor of osteopathy, doctor of podiatry or doctor of dentistry possessing an unlimited license to practice in the State of Indiana.

**“PRESIDENT”** and **“VICE PRESIDENT”** mean the duly elected and authorized President and Vice President of the Medical Staff.

**“PROFESSIONAL REVIEW ACTION”** means any action to evaluate the qualifications of, the patient care rendered by, or the merits of a complaint against, a practitioner, provided that the evaluation of any such complaint shall include a determination or recommendation concerning the complaint.

**“PROFESSIONAL REVIEW COMMITTEE”** or **“PEER REVIEW COMMITTEE”** means the governing body or any committee of the governing body, any committee of the Hospital, and any service, section, or committee of the Medical Staff that conducts professional review activity. Such committees and all personnel of such peer review committees or professional review committees shall and hereby do claim all privileges and immunities afforded to them by the federal Health Care Quality Improvement Act of 1986 and the Indiana Peer Review Act as these may hereafter be amended.

**“QUALITY COMMITTEE”** means the committee charged with reviewing matters of quality management, infection control, pharmacy and therapeutic issues, medical records, and other health care quality and delivery issues, policies and practices, and reporting to the Medical Executive Committee.

**“SECRETARY-TREASURER”** means that member elected by the entire membership of the Active Staff to serve as Secretary-Treasurer of the Medical Staff for the current term of office.

**“UTILIZATION COMMITTEE”** means the committee charged with reviewing and considering matters of utilization review within the hospital and reporting to the Medical Executive Committee.

**“VICE CHAIR OF THE SERVICE”** means the member of the Medical Staff elected by the Active Staff members of that service.

## ARTICLE I

### NAME

The name of the organization shall be THE MEDICAL STAFF OF DUPONT HOSPITAL. The words "Staff" or "Medical Staff" will be used herein to abbreviate the official title.

## ARTICLE II

### PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

#### 2.1 PURPOSES

The purposes of the Medical Staff are as follows:

##### 2.1.A Professional Body

The Staff shall constitute a professional collegial body, providing for its members' mutual education, consultation and professional support, consistent with recognized standards of practice in the community given the state of the healing arts and the available resources.

##### 2.1.B Membership Prerogatives and Clinical Privileges

The Staff shall serve as the professional body that recommends to the Board practitioners eligible for Medical Staff membership, prerogatives and clinical privileges at the Hospital in order to provide clinical services to patients and to engage in teaching.

##### 2.1.C Develop Organizational Structure

The Staff shall develop an organizational structure, reflected in Medical Staff Bylaws and rules, regulations and other protocols adopted pursuant there from, which adequately defines responsibility and concomitant authority and accountability of every organizational component. Such structure shall further be designed to assure that each Medical Staff member exercises responsibility and authority and is subject to appropriate accountability commensurate with his/her current clinical competence to provide patient care and to satisfy the teaching needs of the Hospital.

##### 2.1.D Provide Mechanism for Accountability

The Staff shall be the primary means for accountability to the Board for the appropriateness of Staff members' professional performance and ethical conduct.

##### 2.1.E Provide Means to Formulate Recommendations

The Staff shall provide a means or method by which members of the Medical Staff can formulate recommendations for the Hospital's policymaking and planning processes, and through which such policies and plans are communicated to and observed by each member of the Medical Staff.

#### 2.2 RESPONSIBILITIES

To effectuate the purposes enumerated above, the Medical Staff shall have the following obligations and responsibilities.

2.2.A Participate in Quality Management Program

The Medical Staff shall participate in the Hospital's quality management program by conducting all required and necessary activities for assessing and improving the effectiveness and efficiency of medical care provided in the Hospital, including without limitation the following:

- (1) evaluating practitioner and institutional performance through valid and reliable measurement systems based on objective, clinically sound criteria;
- (2) engaging in the ongoing monitoring of aspects of patient care and enforcement of Medical Staff and Hospital policies;
- (3) evaluating practitioner credentials for initial appointment to, and continued membership on, the Medical Staff and for the delineation of clinical privileges for each individual practitioner in the Hospital through the monitoring and evaluation of each practitioner's performance in the Hospital;
- (4) arranging for Medical Staff participation in programs designed to meet the educational needs of its members; and
- (5) assuring that medical and health care services at the Hospital are appropriately employed for meeting patients' medical, social and emotional needs, consistent with sound health care resource utilization and continuous quality improvement practices.

2.2.B Make Recommendations to the Board

The Medical Staff shall make recommendations to the Board concerning appointments and reappointments to the Medical Staff, including membership category and service and/or other clinical unit designations as applicable, assignments, clinical privileges, specified activities for allied health professionals, and corrective action. The Medical Staff shall also recommend to the Board policies and procedures that define the trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers. The process and procedure for focused professional review shall be substantially in accord with Hospital policy. The information relied upon to investigate a practitioner's professional conduct and practice may include (among other items or information) internal or external chart reviews, prospective, concurrent and/or retrospective monitoring of actual practice, monitoring of clinical practice patterns, proctoring, and consultations with other physicians, assistants, nursing or Administrative personnel involved in the care of patients.

2.2.C Maintain Sound Professional Practices

The Medical Staff shall promote the observance of sound professional practices and the maintenance of an atmosphere conducive to the diagnosis and treatment of illnesses and to teaching and research.

2.2.D Monitor Medical Staff's Education

The Medical Staff shall develop, participate in and monitor the education of and training programs for the membership.

2.2.E Recommend Amendments to Bylaws

The Medical Staff shall develop, administer and recommend amendments to these Bylaws, its supporting manuals, and the rules and regulations of the Medical Staff and its various components.

2.2.F Enforce Compliance with Bylaws

The Medical Staff shall enforce compliance with these Bylaws, its supporting manuals, and the rules and regulations promulgated pursuant hereto as well as the Hospital's operating agreement and policies.

2.2.G Participate in Planning Activities

The Medical Staff shall participate in the Board's short- and long-range planning activities, assist in identifying community health needs and suggest to the Board appropriate institutional policies and programs to meet these needs.

2.2.H. Ensure Maintenance of Ethical Standards

The Medical Staff shall maintain and enforce ethical standards in behavior and practice by its members consistent with the hospital's corporate compliance and ethics policies

2.2.I Exercise Authority Granted

The Medical Staff shall exercise the authority granted by these Bylaws as necessary to fulfill the foregoing responsibilities in a proper and timely manner.

2.3 ORGANIZED HEALTH CARE ARRANGEMENT

Patient information will be collected, stored and maintained so that privacy and confidentiality are preserved. The Hospital and each member of the Medical Staff will be part of an Organized Health Care Arrangement ("OHCA") which is defined as a clinically- integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and the Medical Staff members to share information for purposes of treatment, payment and health care operations. Under the OHCA, at the time of admission, a patient will receive the Hospital's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement between the Hospital and the Medical Staff.

**ARTICLE III**

**MEDICAL STAFF MEMBERSHIP**

3.1 GENERAL QUALIFICATIONS

Membership on the Medical Staff and/or clinical privileges shall be extended only to practitioners who are professionally competent and who continuously meet the qualifications, standards and requirements set forth in these Bylaws and the rules, regulations and other protocols adopted pursuant hereto. Appointment to and membership on the Medical Staff shall confer on the member only such clinical privileges and prerogatives as have been granted by the Board in accordance with the Bylaws.

No practitioner (including those practitioners holding medical administrative positions by virtue of a contract with the Hospital) shall admit or provide service to patients in the Hospital until or unless he/she is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws.

3.1.A Licensure, Board Certification, Performance, and Attitude

Only medical doctors, doctors of osteopathy, doctors of podiatry and doctors of dentistry currently licensed to practice in the State of Indiana, who can document their background, experience, training, demonstrated competence, and adherence to the ethics of their professions shall be qualified for Medical Staff membership and be granted privileges to practice. Effective January 1, 2006, initial applicants (with the exception of dentists) must be Board certified or Board qualified by an approved member of the American Board of Medical Specialties (ABMS) or American Osteopathic Association. If the applicant is Board-qualified,

he/she must achieve Board certification within the time period prescribed by the relevant Board. If Board certification is not obtained within the time period prescribed by the relevant Board, the physician shall no longer satisfy the requirements of this section, and the physician shall not be reappointed as a member of the Medical Staff. These new members of the Medical Staff who are or become Board certified must maintain uninterrupted Board certification by meeting the prescribed recertification requirements of the relevant Board in order to comply with the requirements of this section and be eligible for reappointment.

In order to qualify for membership and/or clinical privileges to practice, it shall also be required that applicants possess and demonstrate a good reputation, judgment, adequate physical and mental competencies, a willingness to participate in the discharge of Staff responsibilities, the ability to work with others with sufficient adequacy to reasonably assure the Medical Staff that any patient treated by them in the Hospital will be given medical care consistent with the recognized standard of practice in the community. The granting of privileges shall be directly related to the delivery of quality of patient care, professional ability and judgment, and community need. No physician who is excluded from participation in Medicare or Medicaid shall be a member of the Medical Staff.

### 3.1.B Basic Obligations of Individual Staff Membership

Acceptance of membership on the Medical Staff shall constitute the member's agreement to:

- (1) strictly abide by the Principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Dental Association or whatever professional ethical code is applicable, as a code may be amended or modified from time to time;
- (2) provide his/her patients with care at the level consistent with recognized standards of practice in the United States and consistent with the practitioner's professional responsibility for medically appropriate and fiscally efficient facility and resource utilization;
- (3) abide by the Medical Staff Bylaws and all other lawful standards, policies, and rules of the Hospital;
- (4) discharge such Medical Staff, committee, Clinical Service and Hospital functions for which he/she is responsible due to Medical Staff category assignment, appointment or election;
- (5) prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or in any way provides care to in the Hospital;
- (6) satisfy the continuing education requirements established by the Medical Staff and/or Clinical Service;
- (7) review these Bylaws and agree that throughout any period of his/her membership he/she will comply with the obligations and requirements of Medical Staff membership and with these Bylaws and the rules, regulations and other protocols adopted and modified from time to time pursuant hereto;
- (8) work cooperatively with Medical Staff members, nurses, and the Hospital administration to promote positive patient care;
- (9) participate in an Emergency Department call schedule that complies with the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations, as well as a rotation for the assignment of unattached patients from the Emergency Department based on need as determined by the clinical services and approved by the Medical Executive Committee;
- (10) respond in a timely fashion to requests for consultations; and

(11) remit such dues as may be levied by the Medical Executive Committee.

3.1.C Nondiscrimination

No practitioner shall be denied membership on the Medical Staff and/or practice privileges because of race, creed, color, ethnic origin, nationality or sex.

3.1.D Disability

Practitioners shall be free of or have adequately accommodated any occupationally relevant physical or behavioral impairment that interferes with, or presents a substantial probability of interfering with, the qualifications required in Article III, Sections 3.1.A and 3.1.B, in such a way that patient care is or is likely to be adversely affected.

3.1.E Current and Projected Patient Care Needs

In acting on new applications for Staff membership and clinical privileges, and on applications for changes in membership status, clinical privileges or Clinical Service affiliation, consideration must be given to and explicit findings made concerning the Hospital's current and projected patient care, teaching and research needs and the Hospital's ability to provide the facilities, beds and support services which will be required if the application is acted upon favorably. Consideration shall further be given to the effect, if any, the addition of the applicant to the Medical Staff will have on the elective surgery schedule or availability of other Hospital facilities. In making these determinations, consideration will be given to effective resource utilization, physician allocation and the Hospital's short- and long-range plans.

The Board may from time to time declare moratoriums in the granting of Medical Staff privileges when the Board, in its discretion, deems such a moratorium to be in the best interest of the Hospital and in the best interest of the health and patients care capable of being provided by the Hospital and its staff. The aforementioned moratoriums may apply to individual medical specialty groups, or any combination thereof. Prior to declaring a moratorium, the Board will seek the input of the Medical Staff regarding the needs of the Hospital and the patient community.

3.1.F Effect of Other Affiliations

No person shall be entitled to membership on the Medical Staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, Staff membership or privileges at another health care facility.

3.2 CONDITIONS AND DURATION OF APPOINTMENT

3.2.A Initial Appointment and Reappointment

Initial appointment and reappointment to the Medical Staff shall be made by the Board according to procedures set forth in these Bylaws and the Credentials Committee Procedures Manual.

3.2.B Initial Appointment and Reappointment Periods

Initial appointment shall be for a period of not less than one year, with the ultimate initial appointment period to be set to permit a synchronized review process for the various Clinical Services throughout the Lutheran Health Network. Reappointments shall be for a period of not more than two years.

3.2.C Privileges Granted in Accordance with Bylaws

Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

3.2.D Acknowledgments Contained in Application

Every application for Medical Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of his/her obligation to provide continuous care and supervision of his/her patients and to abide by these Bylaws, the rules and regulations adopted by the Medical Staff and other laws or regulations applicable to the practice of medicine in the Hospital.

3.2.E Malpractice Insurance

No person may be a member of the Medical Staff unless he/she is certified and qualified as a health care provider under the Indiana Medical Malpractice Act (I.C. 34-18-1-1 et seq.). A copy of the certificate of insurance must be submitted at the time of initial application. At the time of reapplication, the applicant must provide the name of the insurance carrier, the relevant policy number and expiration date of such policy.

3.2.F Evaluation of Applications

The mechanisms for evaluating applications for initial appointment and for conducting periodic reappraisals for reappointment to the Medical Staff are outlined in the Credentials Committee Procedure Manual.

3.2.G Burden of Producing Information

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychological examination limited in scope to matters occupationally relevant to the membership status and/or privilege sought, at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which committee may select the examining physician. All practitioners seeking Medical Staff appointment shall agree to acknowledge the Hospital's obligation to query and report adverse actions to the National Practitioner Data Bank pursuant to 42 U.S.C., 11101-11152, as the same has been and may be amended from time to time.

3.2.H By applying for appointment to the Medical Staff, each applicant:

- (1) signifies willingness to appear for interviews in regard to the application;
- (2) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
- (3) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- (4) releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

- (5) releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- (6) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;
- (7) acknowledges responsibility for timely payment if a requirement then exists for payment of Medical Staff dues;
- (8) pledges to provide for continuous quality care for patients, including timely response to requests for consultations;
- (9) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing continuous care of his/her patients, seeking consultation whenever necessary, and refraining from delegating patient care responsibility to nonqualified or inadequately supervised practitioners; and
- (10) agrees to and acknowledges the Hospital's obligation to query and report adverse actions to the National Practitioner Data Bank pursuant to 42 U.S.C., 11101-11152, as the same has been and may be amended from time to time.
- (11) agrees to be bound by the Medical Staff Bylaws, other lawful standards, and Medical Staff/Hospital policies whether or not granted privileges.

### 3.2.I Obligation to Supplement Information

In addition to the other requirements stated herein, the Medical Staff member must provide the Credentials Committee prompt notice of the following:

- (1) Any legal judgment or settlement involving a finding or acknowledgment of professional malpractice or improper or inappropriate professional conduct;
- (2) Any change, limitation or termination of the member's professional negligence (medical malpractice) insurance coverage;
- (3) Voluntary or involuntary termination, limitation or reduction of the member's medical staff membership and/or privileges at any hospital, ambulatory surgery center or in any managed care organization;
- (4) Termination, limitation or reduction of the member's license, registration or other ability to practice in any jurisdiction; or
- (5) The member's voluntary or involuntary relinquishment of license, registration or other ability to practice in any jurisdiction in lieu of an investigation by that jurisdiction's professional medical licensing authority and/or sanction from such authority.
- (6) Exclusion from any federal or state health program, including Medicare and Medicaid.
- (7) Participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion.

3.2.J Exclusion From Medicare or Medicaid

No person may be a member of the Medical Staff if he/she has been excluded from the Medicare or Medicaid program until and unless the person provides evidence of reinstatement to the Medicare or Medicaid program. Notwithstanding reinstatement, exclusion from the Medicare or Medicaid programs shall be sufficient grounds to deny an applicant Medical Staff membership.

3.3 CONTRACT PRACTITIONERS

3.3.A Contract Practitioners

Contract Practitioners may be retained by the Hospital for any purpose permitted by and consistent with these Bylaws, the Medical Staff rules and regulations, and the operating agreement and rules and regulations of the Hospital. Prior to any final decision being made, the Medical Executive Committee shall review and make recommendations to the Board regarding quality of care issues related to exclusive arrangements for physician and/or professional services, in the following situations: (a) the decision to execute an exclusive contract in a previously open department or service; (b) the decision to renew or modify an exclusive contract in a particular department or service; or (c) the decision to terminate an exclusive contract in a particular department or service.

3.3.B Privileges Required to Admit, Attend Patients

A practitioner under any form of contract with the Hospital for clinical, supervisory or administrative duties may not admit or provide service to Hospital patients unless that practitioner becomes a member of the Medical Staff, with delineated privileges, in accordance with these Bylaws.

3.3.C Termination of Contract

Termination of a contract between a practitioner and the Hospital shall not terminate his/her Staff membership; provided, however, that such contract termination may result in the expiration of privileges pursuant to the terms of said contract. Medical Staff membership may be terminated under Articles IX and X of these Bylaws.

3.3.D Termination of a Practitioner's Medical Staff Membership

Termination of a practitioner's Medical Staff membership or revocation of his/her clinical privileges in accordance with Articles IX and X of these Bylaws is grounds for termination of the contract between the practitioner and the Hospital.

**ARTICLE IV**

**MEDICAL STAFF CATEGORIES**

4.1 CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board and shall be to one of the following Medical Staff categories: Active, Courtesy, Consulting, Honorary, and House.

4.2 ACTIVE STAFF

4.2.A Qualifications

The Active Staff shall consist of practitioners who, in the best judgment of the Credentials Committee, are located in sufficient proximity to the Hospital to provide continuous care of their patients and who assume all of the functions and responsibilities of appointment to the Active Staff in compliance with these Bylaws.

#### 4.2.B Prerogatives and Obligations

A member of the Active Staff shall have the following prerogatives and obligations:

- (1) to exercise such clinical privileges as have been granted by the Board of Directors;
- (2) to vote on all matters presented at general and special meetings of the Medical Staff, any committee thereof and the Clinical Service and/or clinical section of which he/she is a member, and to otherwise participate in all Medical Staff affairs;
- (3) to meet the minimum guidelines for clinical activity during reappointment periods as outlined in the Credentials Manual;
- (4) to exercise such clinical privileges as are granted to him/her;
- (5) to become a Staff officer or a service or committee Chair if so elected or appointed;
- (6) to assist in the clinical, administrative and quality management work conducive and necessary to the professional and efficient operation of the Hospital;
- (7) to attend regular Medical Staff and committee meetings;
- (8) to pay membership dues and other assessments which may become due pursuant to these Bylaws or any rule or regulation adopted pursuant hereto; and
- (9) to counsel freely with other Medical Staff members concerning medical cases and problems.

#### 4.2.C PROVISIONAL STATUS

##### (1) Privileges and Qualifications

Those practitioners who are new Active Staff members or have held Active Staff membership for less than one year shall be subject to provisional status. Such practitioners shall enjoy all clinical privileges granted to them and all other prerogatives enjoyed by Active Staff members.

##### (2) Observation and Evaluation

While subject to provisional status, a practitioner's performance may be observed and evaluated by the Chair of the service with which the practitioner has his/her primary affiliation, and by such other Active Staff members specifically delegated these tasks by such Chair.

#### 4.2.D Noncompliance/Discipline

Failure to comply with any of the above obligations may subject a practitioner to disciplinary action as outlined in Article IX. After two consecutive years during which an Active Staff member fails to care regularly for patients in the Hospital or to be involved regularly in Medical Staff functions as determined by the Medical Staff, such member shall, at the discretion of the Medical Staff, be removed from the Medical Staff or transferred to the appropriate Staff category, if any, for which the member is qualified. A practitioner subjected to action taken pursuant to this Article IV, Section 4.2.D shall not be entitled to the Hearing and Appellate Review rights described in Article X.

#### 4.3 COURTESY STAFF

##### 4.3.A Qualifications

The Courtesy Staff shall be comprised of those practitioners who:

- (1) meet the general qualifications for Medical Staff membership;
- (2) are located in the same proximity to the Hospital as Active Staff members as determined by each clinical service, or demonstrate arrangements that are satisfactory to his/her Clinical Service Chair for alternative medical coverage for patients for whom he/she is responsible; and
  - (a) demonstrate that they are members of the Active or Associate Staff at Lutheran Hospital, Parkview Memorial Hospital or St. Joseph Hospital, or at another Indiana-licensed hospital if a practitioner's primary practice location is not in Allen County, Indiana, but is within Hospital's service area and such hospital observes quality management procedures consistent with those of the Hospital, or
  - (b) agree to fulfill the obligations of Active Staff membership specified in these Bylaws and to participate in quality management activities.

##### 4.3.B Prerogatives and Obligations

Courtesy Staff members shall have the following prerogatives and obligations:

- (1) Courtesy Staff members may admit patients in the same manner as Active Staff members, subject to Article IV, Section 4.2.B (1) and any other requirements of these Bylaws. At such times as the Administrator may determine that the Hospital is operating at full occupancy or that there is otherwise a shortage of Hospital beds and/or other facilities, the elective patient admissions of Courtesy Staff members shall be subordinated to those of Active Staff members.
- (2) Courtesy Staff members shall exercise those clinical privileges that have been granted to them. Courtesy Staff members may attend, in a nonvoting capacity, Medical Staff meetings and meetings of the Clinical Service of which he/she is a member, including open committee meetings and educational programs. Courtesy Staff members shall have no right to vote at such meetings and shall not be eligible to hold office on the Medical Staff or any committee thereof.

##### 4.3.C Provisional Status

- (1) Those practitioners who are new Courtesy Staff members or who have held Courtesy Staff membership for less than one year shall be subject to provisional status. Such practitioners shall enjoy all clinical privileges granted to them and all other prerogatives enjoyed by Courtesy Staff members.

- (2) **Observation and Evaluation**

While subject to provisional status, a practitioner's performance may be observed and evaluated by the Chair of the service with which the practitioner has his/her primary affiliation, and by such Active Staff members specifically delegated these tasks by such Chair.

#### 4.3.D Noncompliance/Discipline

Failure to comply with any of the above obligations may subject a practitioner to disciplinary action as outlined in Article IX. After two consecutive years during which a Courtesy Staff member fails to care regularly for patients in the Hospital, such member shall be, at the discretion of the Medical Staff, removed from the Medical Staff or transferred to the appropriate Staff category, if any, for which the member is qualified. A practitioner subjected to action taken pursuant to Article IV, Section 4.3.D shall not be entitled to the Hearing and Appellate Review rights described in Article X.

#### 4.4 CONSULTING STAFF

##### 4.4.A Definition and Qualifications

A Consulting Staff member must:

- (1) possess specialized skills needed at the Hospital in a specific project or on an occasional basis in consultation when requested by a Clinical Service Chair or other member of the Medical Executive Committee. Unless a Consulting Staff member's patient care contact (consultations, procedures, etc.) are minimal or occasional (as determined by the service to which the member is assigned), the member shall be required to seek Active Staff status not later than twelve (12) months after the granting of Consulting Staff status; provided, however, that the Medical Executive Committee may require the Consulting Staff member to seek Active Staff status earlier than the expiration of such twelve (12) month period; and
- (2) demonstrate active participation on the Active Staff or Associate Staff at another hospital requiring quality management activities of a substance and character similar to those at this Hospital or agree to fulfill the obligations of the Active Staff membership specified in Article IV, Section 4.2.B concerning participation in quality management activities at the Hospital.

##### 4.4.B Prerogatives of Consulting Status

A Consulting Staff member may exercise such clinical privileges as are granted to him. Consulting Staff members are not eligible to admit patients to the Hospital, to hold office in the Medical Staff organization, or to vote at meetings of the Medical Staff.

##### 4.4.C Obligations of Consulting Status

The obligations of Consulting Staff status are as provided in Article III, Section 3.1.B, and Article IV, Section 4.4.A (2).

#### 4.5 HONORARY STAFF

##### 4.5.A Membership on the Honorary Staff is restricted to two classes of practitioners:

- (1) former Medical Staff members whom, upon retirement from practice, the Medical Staff wishes to honor in recognition of longstanding service to the Hospital or other noteworthy contributions to its activities; and
- (2) other practitioners of outstanding professional attainments. None of the specific qualifications, prerogatives or obligations provided for other Medical Staff categories are applicable to Honorary Staff members, and Honorary Staff members shall not be subject to the reappointment and/or evaluation procedures applicable to other Medical Staff members.

4.5.B Honorary Staff Limitations

Honorary Staff members shall have no clinical or other privileges and may not hold office in the Medical Staff organization.

4.6 HOUSE STAFF

4.6.A Definitions and Qualifications

The House Staff shall be comprised of resident practitioners-in-training and medical students who are participating in the Fort Wayne Medical Education Program.

4.6.B Obligations, Prerogatives and Responsibility

The general duties and activities of residents and medical students in the Hospital shall be defined by the Fort Wayne Medical Education Program or its successors. House Staff members shall not enjoy any of the Hearing and Appellate Review rights applicable to other Medical Staff members by these Bylaws.

4.6.C Appointment

Members of the House Staff shall be appointed pursuant to Article IV, Section 4.7.A of these Bylaws .

4.7 LIMITATION OF PREROGATIVES

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

**ARTICLE V**

**DELINEATION OF PRACTICE PRIVILEGES FOR PRACTITIONERS**

5.1 EXERCISE OF PRIVILEGES

A practitioner providing clinical services at this Hospital by virtue of Medical Staff membership or otherwise may exercise, in connection with such practice and except as otherwise provided in Article V, Section 5, only those clinical privileges specifically granted to him by the Board. Regardless of the level of privileges granted, each practitioner must obtain consultation when necessary for the safety of his/her patient or when required by the rules, regulations or other policies of the Medical Staff, any of its clinical units, or the Hospital.

5.2 BASES FOR DETERMINATION OF PRIVILEGES

Privileges governing clinical practice are granted in accordance with prior and continuing education, training, experience, and demonstrated current competence and judgment as documented and verified in each practitioner's credentials file and in accordance with the criteria set forth in Article III, Section 3.1.E. The bases for privileges determinations for current Medical Staff members or any person granted practice privileges in connection with reappointment or a requested change in privileges must include observed clinical performance and documented results of the Medical Staff's quality management program activities.

5.3 SYSTEM AND PROCEDURE FOR GRANTING AND DELINEATING PRIVILEGES

The various levels of clinical privileges, the specific qualifications for the exercise of privileges at each level, and the procedures by which requests for clinical privileges are processed are provided in the Credentials Committee Procedure Manual.

#### 5.4 SPECIAL CONDITIONS FOR ACTIVE PRIVILEGES

Surgical procedures may be performed by dentists and qualified oral surgeons (as defined by individual practitioner's privilege forms), and shall be performed under the overall supervision of the Chair of the Surgery Clinical Service. All dental patients who undergo general anesthesia shall receive a basic medical appraisal by a physician member of the Medical Staff or a qualified oral surgeon who is granted privileges to perform such procedures. A physician member of the Medical Staff shall also be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization. An evaluation of the overall medical risk to the patient's health of a dental surgical procedure shall be made by a physician member or a qualified oral surgeon and these findings shall be recorded in the medical record.

#### 5.5 EMERGENCY & DISASTER PRIVILEGES

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a specific patient is in immediate danger, and delay in administering immediate treatment would add to that danger and no appropriately credentialed individual can be available in the time required to respond, any Medical Staff member, assisted as necessary, is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the member's license, but regardless of service or other clinical unit affiliation, Medical Staff category or level of privileges. A practitioner exercising emergency privileges is expected to summon consultative assistance deemed necessary.

A "disaster" for purposes of this section is defined as a community-wide disaster or mass injury situation in which the number of existing, available medical staff members is not adequate to provide all clinical services required by the citizens serviced by this facility. Disaster privileges may be granted by the CEO or Medical Staff President when, and for so long as, the Hospital's emergency management plan has been activated and the Hospital is unable to handle the immediate patient needs. Prior to granting any disaster privileges the volunteer practitioner, or licensed independent practitioner, shall be required to present a valid photo ID issued by a state, federal or regulatory agency, and at least one of the following : a current hospital picture ID which clearly identifies professional designation; a current license, certification or registration; primary source verification of licensure, certification or registration (if required by law to practice a profession); ID indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP); ID indicating the individual has been granted authority to render patient care, treatment, and services in a disaster, or ID of a current medical staff member who possesses personal knowledge regarding the volunteer practitioner's qualifications. The CEO and/or Medical Staff President are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis.

As soon as possible after disaster privileges are granted, but not later than seventy-two (72) hours thereafter, the practitioner shall undergo the same verification process for temporary privileges when required to address an emergency patient care need. In extraordinary circumstances in which primary source verification of licensure, certification or registration cannot be completed within seventy-two (72) hours, it shall be done as soon as possible, and the Hospital shall document in the emergency/disaster volunteer's credentialing file why primary source verification cannot be performed in the required timeframe, the efforts of the practitioner to continue to provide adequate care, treatment and services, and all attempts to rectify the situation and obtain primary source verification as soon as possible. In all cases, whether or not primary source verification could be obtained within seventy-two (72) hours following the granting of disaster privileges, the Medical Staff President, or his /her designee, shall review the decision to grant the practitioner disaster privileges, and shall, based on information obtained regarding the professional practice of the practitioner, make a decision concerning the continuation of the practitioner's disaster privileges.

In addition, each practitioner granted disaster privileges shall be issued a Hospital ID (or if not practical by time or other circumstances to issue official Hospital ID, then another form of identification) that clearly indicates the identity of the practitioner, and the scope of the practitioner's disaster responsibilities and/or privileges. A member of the hospital staff shall be assigned to each disaster volunteer practitioner for purposes of overseeing the professional performance of the volunteer practitioner through such mechanism of direct observation of care, concurrent or retrospective clinical record review, mentoring, or as otherwise provided in the grant of privileges.

## 5.6 TEMPORARY PRIVILEGES

### 5.6.A Conditions

Temporary privileges may be granted only in the circumstances described in these Bylaws, to an appropriate licensed practitioner only when all required information supports a favorable determination regarding the requesting practitioner's qualifications, current licensure, clinical competence, ability and judgment to exercise the privileges requested, and only after the practitioner has satisfied the professional liability insurance requirement of these Bylaws. Temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Bylaws, rules, regulations and policies of the Medical Staff and Hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, said Bylaws, rules, regulations and policies control all matters relating to the exercise of temporary privileges. In these cases only, the Administrator upon recommendation of either the applicable Clinical Service Chairman or the Medical Staff President may grant such privileges upon completion of the appropriate application, consent, and release, proof of current licensure, DEA certificate, appropriate malpractice insurance, and completion of the required Data Bank query and upon verification that there are no current or prior successful challenges to licensure, or registration, that the physician has not been subject to involuntary termination of Medical Staff membership at another facility, and likewise has not been subject to involuntary limitation, reduction, denial or loss of clinical privileges at another facility.

Temporary privileges may not be granted pending processing of applications for appointment or reappointment.

### 5.6.B Circumstances

Temporary privileges will only be granted in the following circumstances:

- (1) To fulfill an important patient care need

Temporary privileges can be granted on a case-by-case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. Examples of this would include, but are not limited to:

- A situation where a physician becomes ill or takes a leave of absence and another practitioner would need to cover his/her practice until he/she returns
- A specific practitioner has the necessary skills to provide care to a patient that a current Medical Staff member does not possess

In these circumstances, temporary privileges may be granted by the Administrator upon recommendation of either the applicable Clinical Service Chair or the President of the Medical Staff provided there is verification of:

- Current licensure
- Current competence

- (2) Upon receipt of a written request, any appropriately licensed person who is serving as locum tenens for a member of the Medical Staff may, without applying for membership on the Medical Staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for successive consecutive periods not to exceed thirty (30) days, but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred and twenty (120) days of service as locum tenens within a calendar year. All physicians providing coverage through such locum tenens services must ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of locum tenens privileges pursuant to this section. Further, prior to award of locum tenens privileges, the applicant must submit a completed application, a photograph, proof of appropriate malpractice insurance, the consent and re-

lease required by these bylaws, copies of the practitioner's license to practice medicine, DEA certificate and telephone confirmation of privileges at the practitioner's primary hospital. The letter approving locum tenens privileges shall identify the specific privileges granted.

Members of the Medical Staff seeking to provide coverage through locum tenens physicians shall, where possible, advise the Hospital at least thirty (30) days in advance of the identity of the locum tenens and the dates during which the locum tenens services will be utilized in order to allow adequate time for appropriate verifications to be completed. Failure to do so without good cause shall be grounds for corrective action.

#### 5.6.C Termination

On the discovery of information or the occurrence of any event of a nature that raises the question about a practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, the Administrator or the President of the Medical Staff may terminate any or all of a practitioner's temporary privileges. If the life or well-being of a patient is determined to be endangered, then termination may be effected by any person entitled to impose summary suspensions under these Bylaws. In the event of any such termination, the practitioner's patients in the Hospital shall be assigned to another practitioner by the Chair of the Clinical Service responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. No term of temporary or locum tenens privileges shall exceed a total of one hundred and twenty (120) days.

#### 5.6.D Rights of Practitioner

A practitioner is not entitled to the procedural rights afforded by the Bylaws because his/her request for temporary privileges is refused or because all or any portion of his/her temporary privileges are terminated or suspended.

## ARTICLE VI

### STAFF OFFICERS AND COMMITTEES

#### 6.1 GENERAL OFFICERS OF THE STAFF

##### 6.1.A Identification

- (1) President
- (2) Vice President
- (3) Secretary-Treasurer

##### 6.1.B Qualifications

- (1) Each general officer must be a member of the Active Staff at the time of nomination and election, must remain a member in good standing continuously during his/her term of office, and must be willing and able to faithfully discharge the duties of the office held. The President and Vice President must have demonstrated executive ability and be recognized for their high level of clinical competence.
- (2) A member may not hold two general Staff offices concurrently, and a member may not serve simultaneously as a general Staff officer and as a Clinical Service Chair.
- (3) A member serving as a Medical Staff officer or as a member of the Medical Executive Committee may not serve as a Medical Staff or corporate officer, department Chair, Credentials

Committee Chair or in any other official, recognized capacity at another hospital, and he/she may not so serve at another hospital during his/her term of office. Nothing herein, however, shall be construed to prohibit a Medical Staff officer or Medical Executive Committee member from serving as a member of a medically related, nongoverning medical staff committee at another hospital.

(4) A member may serve as Medical Staff officer when his/her election or appointment as an officer is confirmed by the Board.

## 6.2 TERM OF OFFICE

The term of office of general Medical Staff officers is two Medical Staff years. Officers assume office on the first day of the Medical Staff year following their election. An officer elected to fill a vacancy assumes office immediately upon election. Each officer serves until the end of his/her term and until a successor takes office, unless he/she sooner resigns or is removed from office.

## 6.3 ATTAINMENT OF OFFICE

### 6.3.A Of President

The President shall attain office by automatic succession and shall succeed from Vice President.

### 6.3.B Of Vice President and Secretary-Treasurer

(1) At every other regular September meeting of the Medical Staff, the Nominating Committee shall present the names of nominees for the offices of Vice President and Secretary-Treasurer. At the September meeting of the Medical Staff, additional nominations from the floor may be made. Thereafter, the slate shall be closed.

(2) Election of officers shall take place at the September meeting of the Medical Staff. Election shall be by secret ballot if more than one candidate exists for a given office. A majority vote of all eligible members present at a meeting in which a quorum is present shall be required for election.

## 6.4 VACANCIES IN OFFICE

### 6.4.A In the Office of President

A vacancy in the office of President is filled by succession of the Vice President. If the unexpired term has six months or more to run, such service by succession is only for the balance of the unexpired term. If the unexpired term has fewer than six months to run, the Vice President both completes the unexpired term and serves an additional two-year term as President.

### 6.4.B In the Office of Vice President

A vacancy in the office of Vice President shall be filled by holding a special election for the purpose of electing a new Vice President. This election shall be held within 45 days of the creation of the vacancy to fill the office until the next regular election. At least 30 days prior to the scheduled election date, the Nominating Committee shall meet and select nominees for Medical Staff consideration, according to Article VI, Section 6.3.B.

### 6.4.C In the Office of Secretary-Treasurer

A vacancy in the office of Secretary-Treasurer shall be filled in the same manner as for the Vice President of Staff, as set out in Article VI, Section 6.4.B.

6.4.D Simultaneous Vacancies

If there should exist, for any reason, simultaneous vacancies in two or more offices, the vacant offices shall be filled by the procedures listed in Article VI, Sections 6.4.A-6.4.C to the extent applicable.

6.5 ELIGIBILITY FOR REELECTION

A Staff member who has served as President is not eligible again for nomination or election to the office of Vice President until one year has elapsed since he/she held the position of President. A Staff member who has served as Secretary-Treasurer is eligible for reelection to that office, but may serve no more than two consecutive two-year terms.

6.6 RESIGNATION AND REMOVAL FROM OFFICE

6.6.A Resignation

Any general Medical Staff officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation, which may or may not be made contingent upon formal acceptance, takes effect on the date of receipt or at any later time specified in the letter of resignation.

6.6.B Removal Process

Removal of a general Medical Staff member may be effected for any reason not precluded by law by a two-thirds vote by secret ballot of the members of the Staff present and voting, such vote to be taken at a special meeting called for that purpose. Removal may be initiated by the Medical Executive Committee or by a petition signed by at least one third of the Active Staff members.

6.7 DUTIES OF OFFICERS

6.7.A President

The duties of the President, the chief elected officer of the Medical Staff, are as follows:

- (1) to act in coordination and cooperation with the Administrator of the Hospital in all matters of mutual concern within the Hospital;
- (2) to call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
- (3) to Chair the Medical Executive Committee, and serve as a nonvoting member of the Hospital Board;
- (4) to serve as an *ex officio* member of all other Medical Staff committees;
- (5) to be responsible for the enforcement of Medical Staff Bylaws, rules and regulations, and for implementation of sanctions where they are indicated;
- (6) to appoint Medical Staff committee members to all standing, special and multidisciplinary Medical Staff committees except the Medical Executive Committee and the Credentials Committee;
- (7) to represent the views, policies, needs, and grievances of the Medical Staff to the Board and to the Administrator;
- (8) to receive the policies of the Board and interpret them for the Medical Staff;

- (9) to be responsible for the educational activities of the Medical Staff;
- (10) to speak for the Medical Staff in its external professional and public relations; and
- (11) to serve as physician in charge of disaster drill coordination;
- (12) confer with the CEO, CFO, CNO and Service Chairman on at least a quarterly basis as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff, and report on the same to MEC and the Board; and
- (13) assist the Service Chairmen as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members

#### 6.7.B Vice President

In the absence of the President, he/she shall assume all the duties and have the authority of the President. He/she shall be a member of the Medical Executive Committee. He/she shall automatically succeed the President when the latter fails to serve for any reason. In addition, the Vice President shall be responsible for serving as Chair of the Credentials Committee.

#### 6.7.C Secretary-Treasurer

In the absence of the Vice President, he/she shall assume all the duties and have the authority of the Vice President. He/she shall be a member of the Medical Executive Committee. In addition, he/she shall be responsible for:

- (1) initiating and supervising the Medical Staff's nomination and election of officers;
- (2) supervising the maintenance of financial records of the Medical Staff and supervising the collection of dues and assessments; and
- (3) supervising the keeping of minutes for regular and special Medical Staff meetings.

### 6.8 MEDICAL STAFF COMMITTEES

#### 6.8.A General Provisions

- (1) Composition and Appointment to Committees. Staff committees established to perform one or more of the functions required by these Bylaws shall be composed of members of the Active Staff and shall include, where appropriate, allied health professionals, hospital administrators, nursing services Staff, hospital residency Staff, and appropriate hospital departments. The composition of each standing committee shall be as stated in the definitions portion of these Bylaws. The Medical Staff President and the Administrator, or their designees, may serve as ex-officio members without vote on all committees unless otherwise expressly provided.
- (2) Term and Removal. Committee members shall be appointed or determined pursuant to these Bylaws. A committee member shall continue to serve until his successor is elected or appointed. A Staff committee member, other than one serving ex-officio, may be removed by majority vote of the Medical Executive Committee; provided that administration members may be removed by the Administrator.
- (3) Vacancies. Unless otherwise specifically provided, a vacancy on a Staff committee shall be filled in the same manner in which the original appointment to such committee is made.

(4) Meetings. A Staff committee established to perform one or more of the Staff functions required by these Bylaws shall meet at least annually, unless these Bylaws specifically state otherwise. The committee Chair, in each instance, shall schedule such meetings as are necessary for the committee to carry out its functions and duties.

(5) Committee Secretary. A secretary for each committee will be appointed by the committee Chair. The duty of the committee secretary shall be to keep accurate minutes of committee meetings. The committee secretary will prepare a copy of each meeting's minutes, including a record of committee attendance, and forward the same to the President for Medical Executive Committee review.

(6) Standing and Ad Hoc Committees. Standing committees shall be: Medical Executive Committee, Credentials Committee, Quality Committee, Utilization Committee and Conflict Resolution Committee. The President may appoint *ad hoc* committees from time to time on the recommendation of the Medical Executive Committee. Subcommittees of standing committees may also be appointed by the President on the recommendation of the Medical Executive Committee or by a committee Chair. The functions of subcommittees or *ad hoc* committees shall be to carry out functions and duties as required by these Bylaws and other Staff activities as directed by the Medical Executive Committee or the Board. All committees, standing and *ad hoc*, shall be responsible to the Medical Executive Committee, which shall establish and delineate committee composition and duties where not specifically addressed by these Bylaws. Recommendations and actions of all committees are subject to review and approval by the Medical Executive Committee.

(7) Quorum. Unless otherwise so stipulated, a quorum shall be defined as those voting members present at the meeting.

#### 6.8.B Medical Executive Committee

(1) Goals and Objectives. The committee will consider matters involving professional activities of the Staff and will, at all times and in all matters not inconsistent with these Bylaws, act for the Staff as a whole. The committee will transact routine business between meetings of the Staff, and officers of the committee will transact routine business between committee meetings.

(2) Composition. The Medical Executive Committee shall be composed of the Staff President, who shall Chair the committee; the Staff Vice President; the Secretary/Treasurer, the Chair of the Quality Committee; and the Chair, Vice Chair, the Credentials and Education Coordinator for each Clinical Service, and the Administrator as an ex-officio non-voting member.

(3) Responsibilities and Duties of the Committee. The Medical Executive Committee will determine Staff policy. Each committee member will keep his Clinical Service and Staff colleagues informed of committee activities. In addition, committee members will solicit communications and input from all Staff members concerning issues of committee interest. The committee's specific duties will be:

- a. To coordinate the activities and general policies of the various Clinical Services.
- b. To review, approve and implement new, amended or revised Staff policies and to review annually all action to and for the Staff.
- c. To receive and act upon committee reports and Clinical Service reports.
- d. To consider and act upon all matters which pertain to the care of Hospital patients and the professional conduct and activity of Staff members, including reports or recommendations of any professional review body, and to report such matters to the Board with recommendations for final action.

- e. To provide an avenue of communication between the Staff and the Administrator and the Board.
- f. To recommend action to the President and the Administrator on matters of medico-administrative nature; and to make recommendations to the Board.
- g. To serve in the capacity of an accreditation committee, and to keep the Medical Staff informed on matters related to the Joint Commission on Accreditation of Healthcare Organizations.
- h. To review pertinent information available regarding the performance and clinical competence of individual Staff members and other practitioners with clinical privileges, and as a result of such review, to act on recommendations for reappointments and renewal or changes in clinical privileges.
- i. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.
- j. To recommend actions to the Board in matters related to Quality Improvement, Quality Assurance and/or professional review activity.
- k. To report at each general Medical Staff meeting.
- l. To be empowered to act for the Medical Staff in the intervals between Medical Staff meetings.

(4) Duties of Officers. The duties of the officers of the Medical Executive Committee shall include:

- a. Disposition of all interim affairs of the committee, subject to subsequent review and approval by the entire Medical Executive Committee and organization and circulation of an agenda prior to each meeting.
- b. Responsibility for implementing recommendations and actions taken by the Medical Executive Committee, providing appropriate committee reports, and assisting in the liaison between the Medical Executive Committee, the Medical Staff, Hospital administration, and the Board. All recommendations and actions taken by the Medical Executive Committee must have an effective implementation mechanism.
- c. Submission of a report at each regular meeting regarding the implementation of recommendations adopted at the previous meeting.
- d. Requesting evaluation of practitioners in instances when there is doubt about an applicant's ability to perform the privileges requested. Initiating an investigation of any incident, course of conduct, or allegation indicating that a member of the Medical Staff may not be complying with the bylaws, may be rendering care below the standards established for members of the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment or clinical privileges without limitation, further training, or other safeguards.

(5) Meetings. Meetings of the Medical Executive Committee shall be held regularly at least ten (10) times per year. Special meetings may be called by the Medical Executive Committee officers. All meetings of the Medical Executive Committee will be conducted according to Robert's

Rules of Order, when not inconsistent with these Bylaws, and minutes will be maintained for all meetings.

6.8.C Credentials Committee

(1) Functions and Responsibilities. It shall be the function of the Credentials Committee to review all initial applications for Medical Staff membership and privileges. This review shall include those received from applicants for the Honorary, Active, Courtesy and Consulting Medical Staffs. The Credentials Committee shall review each applicant's record of professional training and experience to determine if the privileges requested are justified. The Credentials Committee shall determine that each application contains adequate documentation of the applicant's ability to satisfy the requirements of these Bylaws for Medical Staff Appointment and the Credentials Committee Procedure Manual.

The Credentials Committee will review, at the request of a Clinical Service Chair, any requests for modification of privileges from a member of the Medical Staff.

The Credentials Committee will review all members being proposed for bi-annual Medical Staff reappointment and forward their written recommendation to the Medical Executive Committee.

When appropriate, and with the approval of the Medical Executive Committee, the Credentials Committee may appoint subcommittees for review of qualifications and requests for privileges in areas of special expertise.

(2) Composition. The committee shall be composed of the Vice President of the Staff, who shall serve as Credentials Committee Chair and the Credentials and Educational Coordinator selected by each Clinical Service.

(3) Meetings. The Credentials Committee shall meet at least ten (10) times per year. The Credentials Committee shall provide the Medical Executive Committee with a written record of each meeting. These minutes shall include a record of those applications for membership and privileges that have been reviewed and include the Committee's recommendations to the Executive Committee as to approval, modification or denial of each applicant's requested membership or privileges.

6.8.D Quality Committee

(1) Functions and Responsibilities. The committee will meet, review and consider matters of quality assurance, infection control, pharmacy and therapeutics, medical records and other health care quality and delivery issues, policies and practices as are referred by the Medical Executive Committee or a Medical Staff member in good standing.

(2) Composition. The committee shall be composed of the Vice Chair of each Clinical Service, a representative appointed by the Administrator, and up to three appointees by the Medical Executive Committee.

6.8.E Conflict Resolution Committee

(1) Functions and Responsibilities. The committee will provide an ongoing process for the management of conflict among leadership groups. The committee shall meet, as needed, specifically when a conflict arises that, if not managed, could adversely affect patient safety or quality of care. When such a conflict arises, the committee shall meet with the involved parties as early as possible to resolve the conflict, gather information regarding the conflict, work with the parties to manage and when possible, to resolve the conflict, and to protect the safety and quality of care.

(2) Composition. The committee shall consist of two (2) members of the Organized Medical Staff who are selected by the Medical Executive Committee (and may not be members of the Board), two (2) Board members who are selected by the Board Chair, and the CEO.

6.8.F Utilization Committee

(1) Functions and Responsibilities. The committee will meet, review, and consider matters of utilization review.

(2) Composition. The committee shall be composed of the Physician Advisor and a minimum of three (3) appointees by the Medical Executive Committee.

**ARTICLE VII**

**CLINICAL SERVICES**

7.1 DESIGNATION

7.1.A Current Clinical Services

The current Clinical Services are listed below.

- (1) Medicine
- (2) Surgery
- (3) OB/Gyn

7.1.B Future Clinical Services

The Medical Staff will periodically restudy this structure and recommend to the Medical Executive Committee and to the Board what action is desirable in creating new Clinical Services or other clinical units, for better organizational efficiency and improved patient care.

7.1C Sections

Clinical Service Chairs may establish Sections consisting of Service members involved in the practice of particular specialties, and may appoint chairs for these Sections. Sections may meet as needed and make recommendations to the Service of which they are a part.

7.2 REQUIREMENTS FOR AFFILIATION WITH CLINICAL SERVICES

Each Clinical Service is a separate organizational component of the Medical Staff, and every Staff member must have a primary affiliation with and membership in the Clinical Service which most closely reflects his/her professional training and experience and the clinical area in which his/her practice is concentrated. A practitioner may be granted membership in one or more other Clinical Services in which he/she has privileges.

The practitioner's exercise of clinical privileges is always subject to the rules and regulations of that Clinical Service and the authority of the Clinical Service Chair.

### 7.3 FUNCTIONS OF CLINICAL SERVICES

#### 7.3.A General Functions

Clinical Services fulfill three functions: administrative, collegial and continuous quality management activities. Through election to Staff offices and clinical representation on committees, the Medical Staff members affiliated with each Clinical Service perform these same functions on a multidisciplinary, Staff-wide, and hospital-wide basis.

#### 7.3.B Administrative Functions

Each Clinical Service will assure that its members contribute their professional views and insights to the formulation of Medical Staff and Hospital policies and plans, will communicate formulated policies and plans back to its members for implementation, and will coordinate the professional services of its members with those of other Clinical Services and units as well as with Hospital and Medical Staff support services.

#### 7.3.C Quality Management Functions

Each Clinical Service will discharge the following quality assurance, continuous quality improvement and accountability functions, either alone or in concert with other organizational components of the Medical Staff and of the Hospital:

- (1) conducting patient reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients in the service. Each service shall routinely collect information concerning significant aspects of patient care provided by such service, periodically evaluate such information and, based on such evaluation, develop objective criteria for use in evaluating and continuously improving patient care. Such evaluation shall include a review of all clinical work performed under the jurisdiction of such service, regardless of whether the Staff member whose work is subject to such review is a member of that particular service. Such review would also include an evaluation of mortality rates and surgical case reviews as appropriate;
- (2) establishing minimum guidelines for the granting of clinical privileges and the performance of specified services within jurisdiction of the service. Each service will also periodically evaluate and make appropriate recommendations concerning the qualification of applicants for appointment or reappointment and clinical privileges within the jurisdiction of such service based upon performance, quality management reviews, treatment outcomes and evidence of continuing medical education;
- (3) monitoring its members' performance, on a continuing basis, for adherence to Staff, Hospital, and Clinical Service policies and procedures, including requirements for alternative coverage and for obtaining consultations, adherence to sound principles of clinical practice generally, appropriate surgical and other procedures, for unexpected clinical occurrences, and for patient safety;
- (4) establishing the Clinical Service's quality assessment committee. Each quality assessment committee is to be chaired by the Vice Chair of its respective Clinical Service. Further details as to the overall quality management program and functions of the program's various components are located in the Hospital's Quality Management Plan, which is incorporated herein by reference; and
- (5) make recommendations to the Medical Executive Committee subject to Board approval of the kinds, types, and amounts of data to be collected and evaluated to allow the Medical Staff to conduct an evidence-based analysis of the quality of professional practice of its members.

#### 7.3.D Clinical Service Officers

In order to accomplish the administrative charge of each Clinical Service, each Clinical Service shall elect the following:

- (1) Clinical Service Chair;
- (2) Clinical Service Vice Chair; and
- (3) Clinical Service credentials and education coordinator.

See Article VIII for a description of each officer's duties.

#### 7.3.E Collegial Functions

Each Clinical Service shall serve as the major peer group for providing clinical and emotional support among and between peers, for teaching, continuing education, and sharing new knowledge, and for providing consultation within the Clinical Service and throughout the Hospital in its specialty area.

- (1) The Clinical Service's quality assessment committee shall serve as the most immediate peer review group for the purpose of assessing its peers' patient care activities and summarizing its findings for review, recommendation, and for approval of recommendations and suggested action by the Clinical Service and the Quality Committee.
- (2) The Clinical Service's credentials and education coordinator shall be primarily responsible within the service for evaluating continuing education requirements and distributing related information. He/she shall also provide consultation and coordinate the development of guidelines and privilege delineations within the Clinical Service in concert with the Clinical Service Chair and Vice Chair. Finally, he/she shall also be the Clinical Service's representative to the Credentials Committee.

### **ARTICLE VIII**

#### **OFFICERS OF CLINICAL SERVICES**

##### 8.1 DESIGNATION AND QUALIFICATIONS OF OFFICERS

###### 8.1.A Chair

Each Clinical Service shall have a Chair who is a member of both the Active Staff and the Clinical Service he/she is to Chair. He/she is to remain in good standing throughout his/her term. He/she shall have demonstrated ability in at least one of the clinical areas covered by the Clinical Service, and must be willing and able to faithfully discharge the functions of his/her office. Each service Chair shall be certified by the specialty board applicable to the Chair's specialty and/or be able to establish, through the clinical privilege credentialing process, that he/she possesses competence and demonstrable professional ability in at least one of the clinical areas covered by such service consistent with the standards established by such board. Each Chair must also demonstrate that he/she is willing and able to faithfully discharge the functions of his/her office. He/she must be approved by the Board.

In addition to the above requirements, each Clinical Service Chair must satisfy the following qualifications:

- (1) He/she must be a member in good standing of the Medical Staff and must maintain such membership and good standing during the term of office;

- (2) There must be no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
- (3) He/she may not then be serving as a Medical Staff or corporate officer, department chief, Credentials Committee Chair or in any other official, recognized capacity at another hospital, and he/she may not so serve at another hospital during the term of office;
- (4) He/she must maintain an active clinical practice at the Hospital;
- (5) He/she must have a history of participation in Medical Staff affairs, including quality review and peer review activities where appropriate;
- (6) He/she must demonstrate knowledge concerning the duties of the office;
- (7) He/she must possess competent written and oral communication skills commensurate with the requirements of the office;
- (8) He/she must possess and have demonstrated an ability to work effectively within interpersonal relationships; and
- (9) He/she may not be an employee of another hospital.

#### 8.1.B Vice Chair

The Vice Chair shall be a member of both the Active Staff and the Clinical Service he/she is to serve. He/she is to remain in good standing throughout his/her term. He/she shall have demonstrated ability in at least one of the clinical areas covered by the Clinical Service, and must be willing and able to faithfully discharge the functions of his/her office. The Vice Chair does not automatically become Clinical Service Chair for the following term of office by virtue of election as Vice Chair.

#### 8.1.C Clinical Service Credentials and Education Coordinator

Each Clinical Service shall have a credentials and education coordinator who must be a member of both the Active Staff and the Clinical Service for which he/she is to coordinate the medical education activities. Each coordinator must remain in good standing throughout his/her term, and must be willing and able to faithfully discharge the functions of his/her office. Each coordinator shall be elected for a two-year term.

## 8.2 SELECTION

Clinical Service Chairs, Vice Chairs, and Clinical Service credentials and education coordinators are elected by majority vote by secret ballot of those members of the Clinical Service who are eligible and qualified to vote for Clinical Service officers and are present and voting at the regular Clinical Service meeting in October of any year in which the service officers are to be elected.

Nominations may be made and seconded at the meeting by any Active Staff member of the Clinical Service in good standing, provided that evidence is presented to the meeting of the qualifications of the nominee and that the nominee accepts the nomination.

## 8.3 TERM OF OFFICE

8.3.A Chairs and Vice Chairs shall serve a two-year term commencing on the first day of January following their election and continuing until their successors are chosen, unless they sooner resign or are removed from office. The terms of these two officers shall be staggered where possible so that vacancies due to expiring terms do not occur simultaneously in all such Chairs. The Chairs and Vice Chairs are eligible for reelection.

8.3.B A Clinical Service credentials and education coordinator shall serve a two-year term commencing on the first day of January following election and continuing until his/her successor is chosen, unless he/she sooner resigns or is removed from office. Coordinators are eligible for reelection.

#### 8.4 RESIGNATION AND REMOVAL OF CLINICAL SERVICE OFFICERS

Chairs, Vice Chairs, and credentials and education coordinators may resign at any time by giving written notice to the Medical Executive Committee. Such resignation shall take effect on the date of receipt or at any later time specified in the written notice. Removal of a Clinical Service officer may be effected for any reason not precluded by law by a two-thirds majority vote of the Medical Executive Committee, or by a two-thirds majority vote of the members of the Clinical Service eligible to vote.

#### 8.5 VACANCIES

Any unexpected vacancy in an elected officer position will be filled by an acting officer appointed by the Medical Staff President following consideration of the recommendations of the members of the Clinical Service. The acting officer will serve until an appropriate special election can be held.

#### 8.6 RESPONSIBILITY AND AUTHORITY OF OFFICERS

##### 8.6.A Responsibility and Authority, Chair

A Clinical Service Chair will have the responsibility and authority to do everything necessary to carry out the functions delegated to him and his/her Clinical Service by the Medical Executive Committee, by these Bylaws, or any of the related manuals.

In addition to the above responsibilities, each Clinical Service Chair is responsible for:

- (1) Coordinating all clinical and related activities of the service;
- (2) Coordinating all administrative and related activities of the service, unless such coordination is otherwise provided for by the Hospital;
- (3) Integrating the service into the primary function of the Hospital organization;
- (4) Coordination and integration of interdepartmental and intradepartmental services;
- (5) The development and implementation of policies and procedures to guide and support the provision of services;
- (6) Recommending a sufficient number of qualified and competent persons to provide service;
- (7) Continuing observation and review of the professional performance of all practitioners having delineated clinical privileges in the service;
- (8) Recommending to the Medical Staff criteria for clinical privileges to be granted in the service;
- (9) Recommending clinical privileges for each member of the service;
- (10) Determining the qualifications and competence of service personnel who are not licensed independent practitioners but who also provide patient care services within the service;

- (11) The continuous assessment and improvement of the quality of care and services provided;
- (12) Maintaining a quality control program, as appropriate;
- (13) Coordinating orientation and continuing education programs for all persons in the service; and
- (14) Making recommendations for space and other resources required by the service, as well as making recommendations concerning off-site resources needed for patient care services not provided by the service or Hospital organization, to appropriate Hospital authorities.

#### 8.6.B Responsibility and Authority, Vice Chair

A Clinical Service Vice Chair will have the responsibility and authority to do everything necessary to carry out the functions delegated to him and his/her Clinical Service by the Medical Executive Committee, the Chair of his/her service, these Bylaws, or any of the related manuals. As Vice Chair, he/she shall serve on the Quality Committee, and act for the Clinical Service Chair in his/her absence.

#### 8.6.C Clinical Service Credentials and Education Coordinator

A Clinical Service credentials and education coordinator will have the responsibility and authority to carry out whatever functions are delegated to him by the Medical Executive Committee, the Clinical Service Chair, the Credentials Committee, these Bylaws, or any of the related manuals.

### 8.7 REPORTING RESPONSIBILITIES

#### 8.7.A Clinical Service Chair

The Clinical Service Chair shall report as follows:

- (1) at all regularly scheduled meetings of both the Medical Executive Committee and Medical Staff meetings, about his/her Clinical Service's activities;
- (2) whenever necessary or requested, to the President of the Medical Staff or other practitioner fulfilling the duties of the President, on matters of immediacy, especially where action to coordinate Clinical Services to maintain quality or to assure patient safety is at issue; and
- (3) to the Administrator on issues relating to the Chair's administrative duties for supervision of Hospital personnel, proper functioning of equipment, efficient scheduling and similar matters.

#### 8.7.B Clinical Service Vice Chair

The Clinical Service Vice Chair shall report as follows:

- (1) at all regularly scheduled patient care assessment committee meetings, Clinical Service meetings, and other meetings as needed in regard to the Clinical Service's quality assurance activities; and
- (2) whenever necessary or requested by the President of the Staff, when filling in for the Chair, on matters of immediacy.

## ARTICLE IX

### CORRECTIVE ACTION

#### 9.1 ROUTINE CORRECTIVE ACTION

9.1.A Criteria for Initiation. Whenever the activity or professional conduct of any Staff member with clinical privileges is detrimental to patient safety or to the delivery of high quality patient care, unethical, contrary to these Bylaws or the Hospital's operating agreement and/or rules and regulations or is disruptive to Hospital operations, corrective action against such Staff member may be initiated by the Administrator, the President of the Medical Staff, the Medical Executive Committee or Board. Both the Administrator and the President of the Medical Staff shall designate in writing others persons who may act in their place during their absences to initiate such action.

9.1.B Requests and Notices. All requests for corrective action shall be in writing, supported by reference to the specific activities or conduct that constitute the grounds for the request, and shall be submitted to the President of the Medical Staff. The President of the Medical Staff shall cause the Medical Executive Committee, or an ad hoc committee thereof appointed by the Medical Staff President for the same purpose (hereafter the "Investigative Committee"), to undertake an investigation of the request for corrective action within thirty (30) days of the President's receipt of the request. The affected Medical Staff member may be invited to attend meetings of the Investigative Committee solely for the purpose of assisting the committee to get all the facts during the investigation. Since this investigation is not a hearing, neither the Investigative Committee nor the affected Staff member shall be entitled to be represented by an attorney.

9.1.C Investigative Committee Recommendation. The written report of the Investigative Committee shall include one or more of the following recommendations:

- (1) to reject the request for corrective action;
- (2) to issue a warning, a letter of admonition, or a letter of reprimand;
- (3) to place the affected Staff member on probation or subject the Staff member to required consultation or monitoring;
- (4) to reduce, suspend or revoke clinical privileges for a period not exceeding fourteen (14) days during which a further investigation may be conducted;
- (5) to reduce, suspend or revoke clinical privileges for a period exceeding fourteen (14) days; or
- (6) to suspend or revoke Staff membership.

9.1.D Procedural Rights. Any recommendation by the Investigative Committee pursuant to Subparagraphs 9.1.C (3) (where such action materially restricts a practitioner's exercise of privileges), (5), or (6), or any combination of such actions shall entitle the affected Staff member to the procedural rights specified in Article X. If the recommended action is that provided in Section 9.1.C (1), (2) or (4), such recommendation, together with all supporting documentation, shall be transmitted to the Board.

#### 9.2 SUMMARY SUSPENSION

9.2.A Criteria and Initiation. Whenever a practitioner disregards these Bylaws or whenever the conduct of a practitioner may require that immediate action be taken to protect the life of any patient(s) or other person or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person, the Administrator, President of the Medical Staff, Medical Executive Committee or the Board shall have the authority summarily to suspend the practitioner's Medical Staff

membership and all or portion of the clinical privileges of such practitioner. Such summary suspension shall become effective immediately and the practitioner shall be given prompt written notice of such action by First Class, Certified U.S. Mail to his/her last known business or residential address. It shall be conclusively presumed that the practitioner has received such written notification within three (3) days not counting Sundays or national holidays from the date of such mailing.

9.2.B Procedural Rights. Within seventy-two (72) hours after such summary suspension, a meeting of the Medical Executive Committee shall be convened to review and consider the action taken. The Medical Executive Committee may recommend modification, ratification, continuation with further investigation or termination of the summary suspension. If the summary suspension is terminated or modified such that the practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required. If the summary suspension is continued for purposes of further investigation, the Medical Executive Committee shall reconvene within fourteen (14) days of the original imposition of the summary suspension and shall modify, ratify or terminate the summary suspension. Upon ratification of the summary suspension or modification which materially restricts the practitioner's clinical privileges, the practitioner shall be entitled to the procedure rights provided in Article X.

### 9.3 AUTOMATIC SUSPENSION

9.3.A License. A practitioner whose license, or certificate or other credential authorizing him/her to practice in this state or in at least one hospital in Allen County or contiguous county is revoked, suspended or modified, shall immediately and automatically be suspended from practicing in the Hospital.

9.3.B Drug Enforcement Administration (DEA) Number. A Practitioner whose DEA Number is revoked or suspended shall immediately and automatically be suspended from the Medical Staff and practicing in the Hospital until such time as the registration is reinstated.

9.3.C Malpractice Insurance. Each Staff member shall at all times be and remain a qualified provider under the provision of the Indiana Medical Malpractice Act (I.C. 34-18-1-1 et seq.). A Staff member who fails to remain qualified under the Act shall immediately notify the Administrator of such fact and shall thereupon be suspended immediately and automatically from practicing in the Hospital for so long as he/she remains unqualified under the Act.

9.3.D Exclusion/Suspension from Medicare. Any physician who is excluded from the Medicare program or any state government payor program will be automatically suspended.

9.3.E Procedural Rights.

No Medical Staff member whose privileges are automatically suspended under this Section, shall have the right of hearing or appeal as provided under Article X of the bylaws. The President of the Medical Staff shall designate a physician to provide continued medical care for any suspended practitioner's patients.

## ARTICLE X

### HEARING AND APPELLATE REVIEW PROCEDURE

#### 10.1 GENERAL PROVISIONS

10.1.A If an adverse recommendation or action is taken pursuant to Section 9.1.C (3) (where such action materially restricts a practitioner's exercise of privileges), (5) or (6) above, or Section 5.6.C, the affected Staff member must exhaust the remedies afforded in this Article X before resorting to legal action.

10.1.B For purposes of this Article, the term "affected Staff member" shall include an applicant for appointment or reappointment to the Hospital's Medical Staff unless otherwise stated.

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

10.1.D Recommended adverse actions as described in 9.1.C (3) (5) (6) or 5.6 (c), or any other shall become final only after the hearing and appellate rights set forth herein have either been exhausted or waived.

## 10.2 GROUNDS FOR HEARING

A recommendation or action shall be deemed adverse and entitle a practitioner to procedural rights only if it materially restricts the exercise of privileges and is based upon competence or professional conduct, is practitioner-specific and has been:

- (1) Recommended by the Medical Executive Committee; or
- (2) Taken by the Board contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no right to hearing existed; or
- (3) Taken by the Board on its own initiative without prior recommendation by the Medical Executive Committee.

## 10.3 REQUEST FOR HEARING

10.3.A Notice of Action or Proposed Action. In all cases in which action has been taken or recommendation made as referred to in 10.2 the Administrator or the President of the Medical Staff shall give the affected Staff member prompt written notice of (a) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Indiana Medical Licensing Board except for actions taken pursuant to Section 5.6 (c), (b) the reasons for the proposed action including the acts or omissions with which the member is charged; (c) the right to request a hearing pursuant to 10.3.B and (c) that such hearing must be requested within thirty (30) days and (d) a summary of the rights granted in the hearing pursuant to the provisions in this Article X. If the recommendation or final proposed action adversely affects the clinical privileges of a Staff member for a period longer than thirty (30) days and is based on the competence or professional conduct of the member, such written notice shall state that the action, if adopted, will be reported to the National Practitioner Data Bank and shall state the text of the proposed request. Such notice shall be mailed by First Class U.S. Mail postage prepaid to the member's last known address as shown in the member's Medical Staff file. It shall be conclusively presumed that the member has received such notice within three (3) weekdays of its mailing, not counting national holidays.

10.3.B Requests for Hearings The affected Staff member shall have thirty (30) days following receipt of the Notice of such action to request a hearing. The request shall be in writing addressed to the Administrator with a copy to the members of the Board. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and to have accepted the recommendation or action involved.

10.3.C Time and Place for Hearing. Upon receipt of a timely request for a hearing, the Administrator shall schedule a hearing and, within fifteen (15) days give notice to the member of the time, place and date of the hearing. Unless extended by the Hearing Committee (as defined in 10.3.D below), the date of the commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days from the date of the hearing notice provided however, that when the request is received from a member who is under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request. The notice of hearing shall contain a concise statement of the practitioner's alleged act or omissions, and a list by number of specific or representative patient records in question and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing. The notice shall further contain a list of witnesses expected to testify in support of the adverse recommendation or action. Within ten (10) days of receipt of the notice of hearing under Section 10.2, the affected practitioner shall deliver, by special notice, a list of witnesses expected to testify on his/her behalf at the due process hearing.

10.3.D Hearing Committee – Medical Staff. When a hearing is timely requested, the Administrator shall appoint a Hearing Committee. The Hearing Committee shall be composed of not less than three (3) members of the Medical Staff. The members of the Hearing Committee shall gain no direct financial benefit from the outcome, and shall not have acted as accuser, investigator, fact finder, initial decision maker or recommendation maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from among the members of the Active Medical Staff, the Administrator may appoint members from other Staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the Chair. Membership of the Hearing Committee shall consist of one (1) member who has the same healing arts licensure as the affected Staff member and where it is feasible include an individual practicing the same specialty as the affected Staff member. All other members shall have either an M.D. or a D.O. degree.

Board. A hearing occasioned by an adverse action of the Board shall be conducted by a Hearing Committee appointed by the Chairperson of the Board and composed of three (3) people. At least one (1) Active Medical Staff member shall be included on this committee. Should the Board Chairperson find it impossible to appoint a committee meeting the above requirements or otherwise find good cause to utilize a practitioner outside the Medical Staff, he/she may, upon approval by the CEO, appoint a practitioner meeting all requirements of this section with the exception of Active Medical Staff membership. One (1) of the appointees to the committee shall be designated Chairperson. If the matter concerns or arises from issues regarding a practitioner's clinical competence or performance, the Hearing Committee must be composed of three (3) physicians who may or may not be members of the Hospital's Medical Staff.

10.3.E Failure to Appear or Proceed. Failure without good cause of the affected Staff member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntarily acceptance of the recommendations or actions involved.

10.3.F Postponements and Extensions. Once a request for a hearing is initiated timely, postponement and extensions of time beyond the times set forth in these Bylaws may be permitted by the Hearing Committee Chair on the showing, in the Chair's sole discretion, of good cause, or upon agreement of the parties.

## 10.4 HEARING PROCEDURES

### 10.4.A Pre-hearing Procedure

(1) If either the Investigative Committee (which shall advocate on behalf of the action or recommendation forming the Hearing's subject matter) or the affected Staff member requests submission of a list of witnesses or for a list of additional witnesses, each party shall furnish to the other a written list of the names and addresses of those witnesses reasonably expected to give testimony or evidence in support of that party at the Hearing. The furnishing of witness lists hereunder shall occur as soon as practicable following the request, and in any event at least twenty (20) days before the Hearing provided the timing of the request so permits. In order to enable the affected Staff member to prepare a defense, the affected Staff member shall have the right to inspect and copy documents or other evidence upon which the charges are based and shall also have the right to receive, at least twenty (20) days prior to the Hearing, copies of such documents and evidence, including all evidence which was considered by the Investigative Committee in determining whether to make its recommendation and any exculpatory evidence in the possession of the Hospital or the Medical Staff. The affected Staff member and the Administrator shall have the right to receive all evidence that will be made available to the Hearing Committee.

(2) Upon written request, the Administrator and the Members of the Hearing Committee shall have the right to inspect and copy at their expense any documents or other evidence relevant to the charges which the affected Staff member has in his/her possession or control. Such documents or other evidence produced as soon as practicable following the request, and in any event at least twenty (20) days prior to the Hearing provided the timing of the request so permits.

(3) The failure by either party to provide access to the information described in sections (1) and (2) above at least twenty (20) days before the Hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Staff members other than the member under review.

(4) The Chair shall consider and rule upon any request for access to information and may impose any safe guards of the Hearing/Peer Review process and justice require. In so doing, the Chair shall consider

(a) whether the information sought may be introduced to support or defend the charges,

(b) the exculpatory or inculpatory nature of the information sought if any,

(c) the burden imposed on the party in possession of the information sought if access is granted, and

(d) any previous request of access to information submitted or resisted by the parties to the same proceeding.

(5) The affected Staff member shall be entitled to a reasonable opportunity to question or challenge the impartiality of Hearing Committee members. Challenges to the impartiality of any Hearing Committee member shall be ruled on by the Chair whose decision in that respect shall be final.

(6) It shall be the duty of the member and the Administrator or the members of the Investigative Committee to exercise reasonable diligence in notifying the Chair of the Hearing Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the Hearing. Objections to any pre-Hearing decisions may be succinctly made at the Hearing.

10.4.B Representation. The Hearings provided for in these Bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct, professional competency or character or adverse recommendation pursuant to Section 9.1.C. The affected Staff member shall be entitled to representation by legal counsel in any phase of the Hearing should he/she so choose and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the member shall be entitled to accompanied by and represented at the Hearings by a practitioner licensed to practice medicine or osteopathy in the State of Indiana who is not also an attorney at law and the Administrator or the Investigate Committee shall appoint a representative who may be an attorney at law to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions.

10.4.C The Hearing Officer. The Administrator shall appoint a Hearing Officer to preside at the Hearing. The Chair of the Hearing Committee may seek the advice of the Hearing Officer in making rulings. The Hearing Officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as advocate. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order for procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure or the admissibility of evidence. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the Hearing

Committee, the Hearing Officer may participate in the deliberations of such committee and be legal advisor to it, but the Hearing Officer shall not be entitled to vote.

- 10.4.D Record of the Hearing. A shorthand reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the short hand reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.
- 10.4.E Rights of the Parties. Within reasonable limitations (to be determined in the sole discretion of the Chair and subject to applicable law), both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called by the Investigative Committee and examined as if under cross-examination.
- 10.4.F Miscellaneous Rules. Judicial rules of evidence and procedure relating to the conduct of the Hearing, examination of witnesses, and presentation of evidence shall not apply to a Hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Chair shall have complete discretion in ruling on matters of evidence coming before the Hearing. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Hearing Committee may request or permit both sides to file written arguments.
- 10.4.G Burdens of Presenting Evidence and Proof.
- (1) When a hearing relates to an initial denial of Medical Staff membership, clinical privileges, or advancement in staff category (if such denial materially limits the physician's exercise of privileges), the practitioner who requested the hearing shall have the burden of proving, by a preponderance of the evidence, that the adverse recommendation or action lacks any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory.
- (2) For other matters, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof, but the practitioner thereafter shall be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the grounds therefore lack any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory..
- 10.4.H Adjournment and Conclusion. After consultation with the Chair, the Hearing Officer may adjourn the hearing and reconvene it without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the Hearing. Both the Investigative Committee and the affected Staff member may submit a written statement at the close of the Hearing. Upon conclusion of the presentation of oral and written evidence or the receipt of closing written arguments, if submitted, the Hearing shall be closed.
- 10.4.I Basis for Decision. The decision of the Hearing Committee shall be based on the evidence introduced at the Hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the Hearing Committee shall be subject to such rights of appeal as described in these Bylaws, but shall otherwise be affirmed by the Board as the final action if it is supported by substantial evidence, following a fair procedure.
- 10.4.J Decision of the Hearing Committee. Within fifteen (15) days after final adjournment of the hearing or receipt by the Chair of the Hearing Committee of a transcript of the hearing, (whichever is

later) the Hearing Committee shall render a decision that shall be accompanied by a report in writing and shall be delivered to the Investigative Committee. A copy of said decision also shall be forwarded to the Administrator, the Board, and to the affected Staff member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the Hearing and the conclusion reached. If the final proposed action adversely affects the affected Staff member's clinical privileges for a period longer than thirty (30) days and is based on competence or professional conduct, the decision shall state that the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the report as agreed upon by the committee. Both the member and the Hearing Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be subject to such rights of appeal or review as described in these Bylaws, but shall otherwise be considered and either affirmed, modified or reversed by the Board of Directors as the final action.

## 10.5 APPEAL

- 10.5.A Time for Appeal. Within ten (10) days after receipt of the decision of the Hearing Committee, either the member or the Investigative Committee may request an appellate review. A written request for such review shall be delivered to the President of the Medical Staff, the Administrator and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Board as the final action if it is supported by substantial evidence, following a fair procedure.
- 10.5.B Grounds for Appeal. A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 10.5.E; (c) the text of the report to be filed to the National Practitioner Data Bank is not accurate.
- 10.5.C Time, Place and Notice. If an appellate review is to be conducted, the Appeal Board (as defined in 10.5.D below) shall, within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of such notice, provided however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the Appeal Board for good cause.
- 10.5.D Appeal Board. The Board may sit as the Appeal Board, or it may appoint an Appeal Board, which shall be composed of not less than three (3) members of the Board. 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. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with the respect to the appeal. The attorney selected by the Board shall not be the attorney that represented either party at the hearing before the Investigative Committee.
- 10.5.E Appeal Procedure. The proceeding by the Appeal Board shall be in the nature of an appellate Hearing based upon the record of the Hearing before the Hearing Committee, provided that 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; or the Appeal Board may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the ap-

peal, to present a written statement in support of his/her position on appeal and to personally appear and make oral argument. The Appeal Board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The Appeal Board shall present to the Board of Directors its written recommendations as to whether the Board should affirm, modify, or reverse the Hearing Committee decision, or remand the matter to the Hearing Committee for further review and decision.

10.5.F Decision.

(1) Except as provided in section 10.5.E, within thirty (30) days after the conclusion of the appellate review proceedings, the Board shall render a final decision and shall either affirm, modify or reverse the decision of the Hearing Committee.

(2) The Board may instead, or shall, where a fair procedure has not been afforded, remand the matter to the Hearing Committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the Hearing Committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the Board. The further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Chair of the Board and the Hearing Committee.

(3) The decision shall be in writing, shall specify the reasons for the action taken, shall include the text of the report which shall be made to the National Practitioner Data Bank, if any, and shall be forwarded to the Medical Executive Committee, the subject of the Hearing, the Administrator and the full Board, at least ten (10) days prior to submission to the National Practitioner Data Bank.

10.5.G Right to One Hearing. No member shall be entitled to more than one evidentiary Hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendations, except as provided in paragraph 10.5.F(2) above.

10.6 EXCEPTION TO HEARING RIGHTS

10.6.A If a Medical Staff member provides professional services under a contract with the Hospital, the member's Medical Staff privileges may be terminated upon termination of the contract if the contract so provides. Otherwise, his/her Medical Staff privileges may only expire by affording him/her the same rights of hearing and appeal as are available to all members of the Medical Staff.

10.6.B No hearing is required when a member's license or legal credentials to practice has been revoked or suspended. In other cases, the issues that may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority was unwarranted, but only whether the member may continue practice in the Hospital with those limitations imposed.

**ARTICLE XI**

**MEETINGS**

11.1 MEDICAL STAFF YEAR

For purposes of the business of the Medical Staff, the business year will be the calendar year, commencing on 1 January and expiring on 31 December of that year.

## 11.2 MEDICAL STAFF MEETINGS

### 11.2.A Regular Meetings

An annual Staff meeting shall be held each year. Generally, this meeting shall be held in October. The Medical Executive Committee may authorize the holding of additional general Staff meetings by resolution. The resolution should require notice specifying the place, date and time for the meeting, and specify the agenda for which the meeting is being called.

### 11.2.B Special Meetings

A special meeting of the Medical Staff may be called by the President of the Staff, and must be called by the President at the written request of the Medical Executive Committee or fifteen percent of the members of the Active Staff. A special meeting may also be called by the Administrator of the Hospital, who shall provide notice of the place, date, time and subject matter of any such meeting called.

### 1.2.C Quorum

Unless otherwise so stipulated, a quorum shall be defined as those voting members present at the meeting.

## 11.3 SERVICES AND COMMITTEE MEETINGS

### 11.3.A Regular Meetings

Clinical Services and committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall be required. Each Clinical Service shall meet not less than four (4) times annually at such times and on such dates as are provided by resolution. Unless otherwise so stipulated, a quorum shall be defined as those voting members present at the meeting.

### 11.3.B Special Meetings

A special meeting of any Clinical Service or committee may be called by the Chair thereof, and must be called by the Chair at the written request of the Medical Executive Committee, the President of the Staff, or fifteen percent of the group's current members, but not less than two members. Unless otherwise so stipulated, a quorum shall be defined as those voting members present at the meeting.

## 11.4 ATTENDANCE REQUIREMENTS

### 11.4.A General

Attendance at Medical Staff, Clinical Service and committee meetings is voluntary (not mandatory).

### 11.4.B Special Appearances or Conferences

A practitioner whose patient's clinical course of treatment is scheduled for discussion at Staff, Clinical Service or committee meeting may be notified and invited to present the case.

## ARTICLE XII

### CONFIDENTIALITY, IMMUNITY AND RELEASES

## 12.1 SPECIAL DEFINITIONS

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

12.1.A INFORMATION means records of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, actions, data, and other disclosures or communications whether in written or oral form relating to any of the subject matter specified in Article IX, Sections 12.5.A, 12.5.B and 12.5.C.

12.1.B MALICE means the dissemination of a known falsehood, or of information with a reckless disregard for whether it is true or false.

12.1.C PRACTITIONER means a Medical Staff member or applicant.

12.1.D REPRESENTATIVE means any of the following individuals or groups: a member of the Hospital Board and any director or committee thereof; the Administrator; registered nurses and other employees of the Hospital; the Medical Staff organization and any member, officer, clinical unit, or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or dissemination functions.

12.1.E THIRD PARTIES mean both individuals and organizations providing information to any representative.

## 12.2 AUTHORIZATIONS AND CONDITIONS

By submitting an application for Staff membership or by applying for or exercising clinical privileges or providing specified patient care services in this Hospital, a practitioner does each of the following:

12.2.A Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information being on his/her professional ability and qualifications;

12.2.B Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative or third party who acts in accordance with the provisions of this Article; and

12.2.C Acknowledges that the provisions of this Article are express conditions of his/her application for or acceptance of Staff membership and the continuation of such membership, and his/her exercise of clinical privileges or provision of specified patient services at this Hospital.

## 12.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected, or prepared by any representative of this or any other health care facility or organization or Medical Staff for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, determining that health care services are professionally indicated or were performed in compliance with the applicable standards of care, or establishing and enforcing guidelines to keep health care costs within reasonable bounds shall be confidential to the fullest extent permitted by law, and shall neither be disseminated to anyone other than a representative nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's record.

## 12.4 IMMUNITY FROM LIABILITY

### 12.4.A For Action Taken

Each representative of the Medical Staff and Hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

#### 12.4.B For Providing Information

Each representative of the Medical Staff and Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or hospital concerning such person who is, or has been, an applicant to or member of the Staff or who did, or does, exercise clinical privileges or provide services at this Hospital.

### 12.5 ACTIVITIES AND INFORMATION COVERED

#### 12.5.A Activities

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

- (1) applications for appointment, clinical privileges or specified services;
- (2) periodic reappraisals for reappointment, clinical privileges or specified services;
- (3) corrective or disciplinary action;
- (4) hearings and appellate reviews;
- (5) quality assurance program activities;
- (6) utilization reviews;
- (7) claims reviews;
- (8) profiles and profile analysis;
- (9) malpractice loss prevention; and
- (10) other Hospital and Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

#### 12.5.B Information

The information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

#### 12.5.C Releases

Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

### 12.6 CUMULATIVE EFFECT

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

**ARTICLE XIII**  
**GENERAL PROVISIONS**

13.1 STAFF RULES AND REGULATIONS

The Medical Staff may adopt such rules and regulations and operating and other manuals as the Staff deems necessary to implement more specifically the general principles found in these Bylaws. The rules and regulations and other manuals may not contravene these Bylaws. The rules and regulations are hereby incorporated by reference and made part thereof. To the extent the rules and regulations and other manuals are inconsistent with these Bylaws, the Bylaws shall govern. The procedures outlined in Article XIV of these Bylaws shall be followed in the adoption of the rules and regulations, except that they may be amended or replaced at any regular meeting of the Medical Executive Committee at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote.

13.2 CLINICAL SERVICE POLICIES

Subject to the approval of the Medical Executive Committee and the Board, each Clinical Service will formulate its own written policies for the conduct of its affairs and the discharge of its responsibilities.

13.3 STAFF DUES

The Medical Executive Committee will establish the amount and manner of disposition of annual dues. Dues are payable at the beginning of each new Medical Staff year. Failure, unless excused by the Medical Executive Committee for good cause, to render payment within two months of the start of the new Staff year shall, after special notice of the delinquency, result in automatic suspension of Staff membership, including all prerogatives and clinical privileges until the delinquency is remedied. The Medical Executive Committee, applicable clinical unit heads and organizational components in which the delinquent practitioner holds membership will be notified of the suspension.

13.4 INDEMNIFICATION

13.4.A No person or his/her personal representative shall be liable to the Hospital for any loss or damage suffered by it on account of any action taken or omitted to be taken by such person constituting the negligent performance of duties as a Medical Staff officer, Medical Staff committee member, or officer of a Medical Staff service of the Hospital. In addition, but not in limitation of the foregoing, no person or his/her personal representative shall be liable to the Hospital for any loss or damage suffered by it on account of any actions taken or omitted to be taken by such person in good faith as a Medical Staff officer, Medical Staff committee member, or officer of a Medical Staff service, if such person:

- (1) Exercised and used the same degree of care and skill as a prudent man may have exercised and used under like circumstances, charged with a like duty, or;
- (2) Took or omitted to take such action in reliance upon advice of counsel for the Hospital or such enterprise or upon statements made or information furnished to persons employed or retained by the Hospital or such enterprise upon which we had reasonable grounds to rely. This is not exclusive of other rights and defenses to which such person or his/her personal representative may be entitled under law.

13.4.B Indemnification

Every person who is or shall have been a Medical Staff officer, Medical Staff committee member or officer of a Medical Staff service of the Hospital shall be indemnified by the Hospital against:

- (1) Any and all claims, liability, damages, other recovery in relation to such person by reason of being or serving as a Medical Staff officer, Medical Staff committee member, or officer of a

Medical Staff service, in the amount and to the extent such claim, liability, damage or recovery against that person is not covered or paid by or pursuant to the provisions of a director's and officers' liability policy, professional liability policy, or other liability policy that may be insuring that person; and,

(2) Expenses actually and reasonably incurred by him in connection with the defense of any civil action, suit, or proceeding in which he/she is made or threatened to be made a party by reason of being or having been in any such capacity or arising out of his/her status as such, except in relation to matters as to which he/she shall be adjudged by the trier of fact in such action, suit, or proceeding to be liable for negligence or misconduct in the performance of duty to the Hospital.

Nothing in this provision shall preclude any party from settling any such action, suit or proceeding. If such action, suit, or proceeding shall be settled, or otherwise terminated without final determination on the merits, each such person shall be entitled to the indemnity above provided (except that no person shall be indemnified for any amount paid by him to the Hospital in settlement) upon a determination that

(3) In the case of any action, suit, or proceeding brought or threatened by or in the right of the Hospital to procure a judgment in its favor, such person has not been negligent or engaged in misconduct in the performance of duty to the Hospital as charged; or

(4) In the case of any action, suit, or proceeding brought or threatened by or in the right of the Hospital to procure a judgment in its favor, such person acted in good faith for a purpose which he/she reasonably believed to be in or not opposed to the best interest of the Hospital, and in addition in any criminal action or proceeding that he/she had no reasonable cause to believe that his/her conduct was unlawful.

Such determination shall be made by a group of three or more disinterested persons (which may include independent legal counsel of the Hospital) chosen by the Board. This right to indemnification shall extend to the personal representatives of any such person and shall not be deemed exclusive of, but shall be in addition to, other rights to which any such person and his/her personal representative may be entitled under law.

## **ARTICLE XIV**

### **ADOPTION AND AMENDMENT**

#### **14.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY**

In that the Hospital's Board has delegated to the Medical Staff the authority and responsibility to initiate and recommend to the Board the Bylaws and related protocols establishing the Staff's organizational structure, and governing its processes and manner of acting, subject only to certain limitations detailed in the Hospital operating agreement or by corporate resolution, the adoption and amendment of these Bylaws require the actions specified in Article XIV, Subarticle 14.2 .

#### **14.2 MEDICAL STAFF ACTION**

These Bylaws may be amended by the affirmative vote of a majority of the Medical Staff members present and having voting on such Bylaws, cast at a regular or special Medical Staff meeting at which a quorum is present, provided that a copy of the proposed documents or amendments was given to each Medical Staff member entitled to vote thereon with the notice of the meeting. Such amendment shall not be effective until and unless approved by the Board. It is the intent of this paragraph that neither the Board nor the Medical Staff shall have the ability to unilaterally amend the Bylaws.

If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws when necessary to provide for protection of patient welfare or when necessary to comply with accreditation standards or applicable law. However, should the Board act upon its own initiative as provided in this paragraph, it shall consult with the Medical Staff at the next regular Medical Staff meeting (or at a special meeting as provided in these bylaws), and shall advise the Medical Staff of the basis for its action in this regard.

These Bylaws shall be reviewed at least once every two (2) years.

Approved by the Medical Executive Committee on: November 2, 2009

---

Chairman, Medical Executive Committee

Approved by the Board of Directors on: November 10, 2009

---

Chairman, Board of Directors