LUTHERAN HOSPITAL OF INDIANA
FORT WAYNE, INDIANA

STAFF FUNCTIONS

AND

COMMITTEE MANUAL

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PART I. FUNCTIONS AND COMMITTEES

1.1 Functions of the Staff

The required functions of the Medical Staff are those required by law and those specified in this manual and the Medical Staff Bylaws (the "Bylaws"). They shall be accomplished as indicated in the Bylaws, through assignment to the Staff as a whole, to the clinical services, to Staff committees, to Staff Officers or other individual Staff members, or to interdisciplinary Hospital committees with participation of Medical Staff members. The required functions of the Medical Staff are as follows:

A. To govern, direct, and coordinate the Staff organization and its various functions;

B. To plan, conduct, coordinate, and evaluate the Medical Staff components of the Hospital's quality management program and to continuously strive to improve the quality of patient care;

C. to conduct, coordinate, and evaluate the effectiveness of monitoring activities, including tissue, blood usage, mortality, morbidity, antibiotic and other drug use reviews; analysis of autopsy reports; analysis of unexpected clinical occurrences; fulfillment of consultation requirements; and compliance with the Bylaws, rules, regulations, policies and procedures of the Staff and the Hospital;

D. To conduct, coordinate, and evaluate the effectiveness of the Hospital's utilization review activities;

E. To conduct, coordinate, and evaluate the effectiveness of special studies of the structures, processes, and outcomes of care;

F. To monitor and evaluate care provided in and develop clinical policies for medical-surgical intensive care units, coronary and other special care units, and patient care support services, such as respiratory therapy, physical therapy, pathology, radiology and anesthesiology;

G. To conduct, coordinate, and act on credentials investigations and recommendations regarding Staff membership, grants of clinical privileges, corrective action, and specified services for specified professional personnel and allied health professionals;

H. To provide and evaluate continuing education opportunities, responsive, when appropriate, to quality assurance program findings and to new state-of-the-art developments pertinent to clinical practice in the Hospital;

I. To plan, conduct, coordinate, and evaluate training of medical students and residents;

J. To evaluate and offer consultative advice on the Hospital's professional library services;

K. To develop and review policies and practices on and maintain surveillance over the completeness, timeliness, and clinical pertinence of patient medical and related records;

L. To develop and maintain surveillance over drug use policies and practices;

M. To investigate and monitor hospital-acquired infections and participate in the Hospital's infection control program;

N. To participate in planning for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community;

O. To direct Staff organizational activities, the review and revision of Staff Bylaws, nomination and/or election of Staff Officers and committee nominations, the liaison with the Board and Hospital Administration, and the review and maintenance of Hospital accreditation; and

P. To participate in quality improvement activities within clinical areas and other Hospital activities.

PART II. PRINCIPLES GOVERNING COMMITTEES

2.1 Principles Governing Committees

2.1.A Medical Executive and Other Committees

There will be a Medical Executive Committee and such other standing and special committees, responsible to the Medical Executive Committee or to a designated Staff official, as are necessary and desirable to perform any of the functions listed in Part I, Section 1, of this manual.

2.1.B Substitution

The Medical Executive Committee may, at any time it deems it necessary and desirable for the proper discharge of the functions required of the Staff by the Bylaws and the Bylaws and policies of the Hospital, establish, eliminate, or merge standing or special Staff committees, change the functions of a Staff committee, or assign the function to the Staff as a whole.

2.1.C Representation on Hospital Committees

Staff functions and responsibilities relating to liaison with the Board and the Hospital Administration, Hospital accreditation, disaster planning, facility and services planning, financial management, and functional and physical plant safety which require participation of, rather than direct oversight by the Staff may be discharged in part by various Officers and organizational components of the Staff as described in the Bylaws and the related manuals, and in part by Medical Staff representation on Hospital committees established to perform such functions.

2.1.D Ex Officio Members

The Chief Executive Officer or his designee, as well as the Chief Medical Officer, shall be ex officio members of the Medical Executive Committee and of all other standing and special committees of the Staff. In matters related to peer review activities concerning the Medical Staff, ex officio members who are not Medical Staff members are without vote.

2.1.E Action Through Subcommittees

Any standing committee may elect to perform any of its specifically designated functions by constituting any number of its members as a subcommittee for that purpose, reporting such action to the parent committee and to the Medical Executive Committee in writing. Any such subcommittee may include individuals in addition to members of the standing committee. Such additional members are appointed by the committee chairman after consultation with the President of the Staff and with the Chief Executive Officer or his designee when administrative Staff appointments are to be made.

2.1.F Term, Prior Removal, and Vacancies

When committees are first appointed under the Bylaws, the appointed members will be divided by lot into two groups approximately equal in size. The first group serves a term of one year, the second a term of two years. Thereafter, and except as otherwise expressly provided, each committee member, except one serving ex officio, serves a two-year term, unless he sooner resigns or is removed from the committee or the Staff.

A voting committee member may not be removed arbitrarily or capriciously by action of the Medical Executive Committee. A vacancy in any committee is filled for the unexpired portion of the term in the same manner in which the original appointment is made. Any ex officio member of the Staff committee ceases to be such if he ceases to hold the designated position which is the basis of ex officio membership.

PART III. CANCER COMMITTEE

3.1 Cancer Committee

3.1.A Purpose

The Cancer Committee is a multidisciplinary committee responsible for program leadership, and represents the full scope of care. The committee shall be responsible for the following:

(1) Developing, monitoring, evaluating and reporting annual program goals and objectives;

(2) Promoting a collaborative multidisciplinary approach to cancer care;

(3) Initiating quality or performance improvement studies that focus on access to care and patient outcomes related to cancer;

(4) Providing ongoing professional consultation and educational opportunities through cancer conferences that focus on prospective patient care management and/or complex cancer management issues;

(5) Establishing the quality control plan to ensure the accuracy, timeliness, follow-up and data reporting of the cancer registry data;

(6) Implementing cancer prevention and early detection community outreach programs; and

(7) Ensuring access to cancer-related research, educational and supportive services.

3.1.B Committee Composition

The Cancer Committee shall consist of the following voting members:

(1) Radiation Oncologist;

(2) Medical Oncologist;

(3) Diagnostic Radiologist;

(4) Pathologist;

(5) General Surgeon;

(6) Cancer Liaison Physician; and

Additional specialty physicians representing the major cancer sites seen at the hospital (these physicians will be assessed on an annual basis and identified based on the frequency of cancer experience as documented in the registry data).

The following nonvoting members will represent oncology-related ancillary support services:

(1) Cancer Program Administrator;

(2) Oncology Nurse;

(3) Social Worker or Case Manager;

(4) Certified Tumor Registrar;

(5) Performance Improvement or Quality Management Professional;

(6) Hospice/Home Care Nurse or Administrator; and

(7) Pain Control/Palliative Care Physician or Specialist

The chairman shall be approved by the President of the Medical Staff and shall serve as the medical director of the Cancer Program. The chairman shall designate four (4) coordinators to coordinate, monitor and make recommendations in their assigned areas or established hospital departments or staff leadership to assist in the development of annual goals and objectives, monitor the assigned area of responsibility; provide written reports to the cancer committee; and recommend corrective action as necessary. The four (4) coordinator roles are as follows:

(1) Cancer Conferences;

(2) Quality Control of Cancer Registry;

(3) Quality Improvement; and

(4) Community Outreach

3.1.C Meetings

The committee shall meet as often as necessary, but not less than quarterly. The committee shall report its activities to the Medical Executive Committee on a regular basis.

3.1.D Quorum

A quorum shall be defined as those voting members present at the meeting.

3.1.E Minutes

Officially approved minutes of the Cancer Committee meetings shall be filed in the office of the Executive Director of Oncology Services. Such approved minutes shall be available to voting members of the Staff for review.

PART IV. CREDENTIALS COMMITTEE

4.1 Credentials Committee

4.1.A The Credentials Committee shall serve as the hub for credentials and delineation of practice privileges. It shall receive from the Medical Staff written recommendations and completed applications for Staff appointment, reappointment, Staff category assignment, clinical service affiliations, membership prerogatives, clinical privileges, and corrective actions concerning any of the foregoing. It shall then make recommendations to the Medical Executive Committee to act upon. (See the Credentials Committee Procedure Manual for detail).

4.1.B Credentials Committee shall consist of the following members:

(1) President Elect of the Staff, who is chairman of the Credentials Committee;

(2) Vice President of the Staff, who is vice chairman;

(3) Credentials and Education Coordinator from each clinical service;

(4) The Chief Executive Officer or his designee, who shall serve as an ex officio, voting member of the committee; and

(5) The Chief Medical Officer, who shall serve as an ex officio, voting member of the committee.

provided, however, that, notwithstanding any other provision of this manual, no person who is an employee of another hospital shall serve on the Credentials Committee.

4.1.C Quorum

Four voting members shall constitute a quorum.

4.1.D Meetings

Meetings of the Credentials Committee shall be held monthly at a time and a place specified by the chairman. In the event the attendance is below the quorum or the specified day is a legal holiday, the chairman shall fix an alternate meeting date. Special meetings may be called at the request of two members of the Credentials Committee. Notice of such special meetings must be given to all members five days prior to the date of the meeting. On issues of an emergent nature, in lieu of a special meeting, the chairman may poll members of the committee personally or by telephone. The agreement of a majority of a quorum shall authorize the chairman to act on the issue in question and such action shall be reconsidered at the next regular meeting of the Credentials Committee.

4.1.E Reports

The committee shall report its activities to the Medical Executive Committee on a regular basis.

PART V. CRITICAL CARE COMMITTEE

5.1 Critical Care Committee

5.1.A Purpose

This committee shall be responsible for overseeing the implementation of policies established by the Medical Staff for the continuing operation of the Intensive Care Units. This committee shall assure that the quality, safety, and appropriateness of patient care services provided within the units are reviewed and evaluated on a regular basis and that appropriate action is taken based on the findings of the review and evaluation activities. This committee shall also assure the quality of safety and appropriateness of patient care service and improvement opportunities provided. It shall make recommendations to the Medical Executive Committee as indicated.

5.1.B Committee Composition

The following shall be members of the Critical Care Committee:

Voting:

(1) A minimum of six physicians shall be appointed by the President of the Staff to serve as representatives to the Critical Care Committee. The members of the committee shall represent the major specialties whose patients comprise the majority of admissions to the adult critical care units.

The chairman shall be appointed by the President of Staff and shall serve as the medical director for the adult intensive care units. The vice chairman shall be the chairman of the Cardiology/Cardiovascular Service, who shall serve as medical director for the Coronary Intensive Care Unit.

The chairman shall be board qualified or board certified in medicine, surgery, anesthesiology, or critical care medicine.

The Chief Executive Officer or his designee, as well as the Chief Medical Officer, shall serve as ex officio, voting members of the committee.

Non-Voting:

(1) Division Directors, Intensive Care Units;

(2) Chief Nursing Officer or Assistant Vice President of Nursing;

(3) Respiratory therapist supervisor for critical care areas;

(4) Infection Control Nurse; and

(5) Quality Department representative

5.1.C Quorum

A quorum shall be defined as those voting members present at the meeting.

5.1.D Meetings and Report

The committee shall meet as often as necessary to review and evaluate the quality, safety, and appropriateness of patient care within the Intensive Care Units as they relate to the findings of Hospital and Medical Staff quality and safety assessment activities. Actions taken and recommended by the committee shall be documented. The minutes shall be reviewed by the Medical Executive Committee. Nursing Service and other critical care related policies and procedures shall be reviewed annually, and revised as needed by this committee and forwarded to the Medical Executive Committee. Policies and/or procedures relating to a single critical care unit may be presented directly to the Medical Executive Committee by the physician responsible for that particular critical care unit if expedited action is required between regular meetings.

5.1.E Minutes

Officially approved minutes of the Critical Care Committee shall be filed in the Quality Services Office. Such approved minutes shall be available to voting members of the Staff for review.

5.1.F Reports

The committee shall report its activities to the Executive Committee on a regular basis.

PART VI. MEDICAL EDUCATION COMMITTEE

6.1 Medical Education Committee

6.1.A Purpose

The Medical Education Committee shall coordinate the Medical Staff's continuing education programs, and, in consultation with the Fort Wayne Medical Education Program coordinate and manage the activities of residents and medical students at the Hospital. This committee shall assist in the formula- tion, maintenance, and supervision of a program for the educational training of medical students and residents. This program should be carried out in such a manner as to comply with the standards established by the American Medical Association's Accreditation Council for Graduate Medical Education (ACGME).

This committee shall present credentials of all House Staff to the Credentials Committee prior to the residents' rotations in the Hospital.

6.1.B Composition

The Medical Education Committee shall consist of the following members:

(1) The director of medical education, who shall also be the chairman of the committee;

(2) The clinical services' credentials and education coordinators;

(3) The director of the orthopaedic residency training program;

(4) The assistant director of the family practice residency program for the Hospital;

(5) The Chief Executive Officer or his designee, who shall serve as an ex officio, voting member of the committee; and

(6) The Chief Medical Officer, who shall serve as an ex officio, voting member of the committee.

6.1.C Quorum

A quorum shall be defined as those voting members present at the meeting.

6.1.D Meetings

The committee shall meet as often as necessary to accomplish its stated purpose. At least one meeting shall be held during the month of May to facilitate the credentialing of new residents. On issues of an emergent nature, in lieu of a special meeting, the chairman may poll members of the committee personally or by telephone.

6.1.E Minutes

Officially approved minutes of the Medical Education Committee meetings shall be filed in the Medical Staff Assistance Office. Such approved minutes shall be available to voting members of the Staff for review.

6.1.F Reports

The committee shall report its activities to the Executive Committee on a regular basis.

PART VII. MEDICAL EXECUTIVE COMMITTEE

7.1 Medical Executive Committee

7.1.A The Medical Executive Committee shall serve as the governing body of the Medical Staff. The President of the Staff is automatically chairman and will preside over the Medical Executive Committee. A recording secretary shall be appointed by the President of the Staff. The Medical Executive Committee shall consist of the following voting members:

(1) President of the Staff;

(2) President Elect of the Staff (chairman, Credentials Committee);

(3) Vice President of the Staff (vice chairman, Credentials Committee);

(4) Chairman of each clinical service of Medical Staff;

(5) One member each at large from cardiology/cardiovascular, medicine and surgery services;

(6) Director of medical education;

(7) Chairman of Peer Review Committee;

(8) Chairman of Quality Council;

(9) Chairman of Pharmacy-Therapeutics Committee;

(10) Chairman of the Institutional Review Board;

(11) Chairman of Critical Care Committee;

(12) The immediate past Medical Staff President

(13) The Chief Executive Officer or his designee shall serve as an ex officio, voting member;

(14) The Chief Medical Officer shall serve as an ex officio, voting member; and

provided, however, that, notwithstanding any other provision of this manual, no person who is an employee of another hospital shall serve on the Medical Executive Committee. In the event that any clinical services or listed committees are chaired by co-chairmen, each such co-chairman shall be entitled to attend Medical Executive Committee meetings, but the service or committee shall be entitled to only one vote.

7.1.B The Medical Executive Committee shall discharge the following functions:

(1) Recommend, adopt, amend, and repeal the Rules and Regulations of the Medical Staff, its Credentials Committee Procedures Manuals, Utilization Review and Quality Management plans and all other manuals subject to or referenced in the Bylaws, subject to Article XIV of the Bylaws;

(2) Coordinate the activities and general policies of the Medical Staff and the clinical services of the Staff;

(3) Act for the Staff as a whole under such limitations as may be imposed by the Bylaws and the Rules and Regulations of the Medical Staff;

(4) Receive and act upon the reports of the Medical Staff Services, and of all standing, special, ad hoc and Hospital committees;

(5) Consider and recommend action to the President of the Hospital on all matters of a medico-administrative nature;

(6) Report to the Medical Staff at its annual meeting all principal actions taken in the preceding period;

(7) Inform the Medical Staff of policies and of correspondence with the JCAHO;

(8) Apprise the Medical Staff of policy and procedural changes through the publication of memoranda, the mailing of which shall constitute an official notification of such policy and procedural change to the Staff members concerned;

(9) Recommend to the Board of trustees the acceptance or rejection of applications for initial appointments, the acceptance or rejection of applications for reappointments, recommendations concerning Staff categories, clinical service assignments and clinical privileges of members of the Medical Staff;

(10) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of the Staff members, including but not limited to initiating investigations, pursuing corrective action and affording due process as set forth in the Bylaws;

(11) Authorize the replacement of clinical service chairmen who fail to perform their duties satisfactorily or for any reason are relieved of or resign from office;

(12) Perform such other functions as may be authorized by the Bylaws from time to time, or as may be delegated to it from time to time;

(13) Report to the Board of trustees and to the Medical Staff regarding the overall quality and efficiency of patient care in the Hospital;

(14) Review and approve job descriptions submitted by the Administration of the Hospital and/or Credentials Committee detailing specific patient care activities and responsibilities pertaining to allied health professionals assigned to a member, clinical service, or section of the Medical Staff.

7.1.C Quorum

Six voting members shall constitute a quorum.

7.1.D Meetings

Meetings of the Medical Executive Committee shall be held monthly at a time and place specified by the chairman. In the event the attendance is below the quorum or the specified day is a legal holiday, the chairman shall fix an alternate meeting date. Special meetings may be called at the request of two members of the Medical Executive Committee. Notice of such special meetings must be given to all members five days prior to the date of the meeting. On issues of an emergency nature, and in lieu of a special meeting, the chairman may poll the Medical Executive Committee members personally or by telephone. The agreement of a majority of a quorum shall authorize the chairman to act on the issue in question and such action shall be reconsidered at the next regular meeting of the Medical Executive Committee.

7.1.E Minutes

Officially approved minutes of the Medical Executive Committee meetings shall be filed in the Medical Staff Assistance Office. These minutes shall be available to voting members of the Staff for review.

PART VIII. NOMINATING COMMITTEE

8.1 Nominating Committee

8.1.A Purpose and Function

It shall be the purpose of this committee to select the most qualified candidates willing and able to accept major administrative responsibility for the Medical Staff.

8.1.B Composition

The Nominating Committee shall consist of the members of the Medical Executive Committee, as all clinical services are represented; the Chief Executive Officer or his designee, who shall serve as an ex officio voting member of the committee; and the Medical Director, who shall serve as an ex officio voting member of the committee.

8.1.C Meetings

A single meeting in July shall be held at a time and in a place specified by the chairman, who shall be appointed by the President of the Staff. In the event that attendance is below the quorum or the specified day is a legal holiday, the chairman shall fix an alternate meeting date. The agreement of a majority of a quorum shall authorize the chairman to act on the issue in question and such action shall be considered at the September meeting of the Medical Staff.

8.1.D Minutes

Officially approved minutes of the Nominating Committee shall be filed in the Medical Staff Office. Minutes shall be available to voting members of the Staff for review.

8.1.E Report

The Nominating Committee report shall be mailed to each Active Staff member prior to the date on which the election is to be held.

PART IX. PHARMACY-THERAPEUTICS COMMITTEE

9.1 Pharmacy-Therapeutics Committee

9.1.A Purpose

This committee shall be responsible for the development and surveillance of pharmacy and therapeutics policies and practices, and of all drug utilization policies and practices within the Hospital in order to promote desirable clinical results and reduce the potential for hazard, except for the evaluation and approval of all protocols concerned with the use of investigational or experimental drugs. These policies and procedures shall relate to but not be limited to, selection, intrahospital distribution and handling, procurement, storage, use and safety procedures.

The committee shall serve as an advisory group to the Medical Executive Committee. Written reports shall be maintained that reflect results of all evaluations performed and actions taken. The committee shall also advise the Medical Staff and the Pharmacy on matters pertaining to the drugs available for patient care and diagnostic testing, on additions or deletions of drugs in the Hospital's formulary.

9.1.B Committee Composition

The committee shall consist of six representatives of the Medical Staff, one from each of the following services and/or sections:

(1) Medicine

(2) Surgery

(3) Obstetrics-Gynecology

(4) Family Practice

(5) Anesthesia

(6) Emergency Medicine

The chairman shall be appointed by the President of the Staff and the members shall be appointed by the chairmen of the respective services.

The director of Pharmacy, a clinical pharmacist, and one representative each from Nutritional Services, and Nursing shall also be voting members.

The Chief Executive Officer or his designee, as well as the Chief Medical Officer, shall serve as ex officio, voting members of the committee.

9.1.C Meetings and Reports

This committee shall meet at a time and place as designated by the chairman, but not less than quarterly. All minutes and written reports shall be forwarded to the Medical Executive Committee.

9.1.D Quorum

A quorum shall be defined as those voting members present at the meeting.

9.1.E Minutes

Officially approved minutes of the Pharmacy-Therapeutics Committee meetings shall be filed in the Quality Services Office. Such approved minutes shall be available to voting members of the Staff for review.

PART X. PHYSICIAN IN NEED COMMITTEE

10.1 Physician in Need Committee

10.1.A Purpose

This committee is formed to assure the quality and safety of care provided the Hospital's patients by attempting to identify any instance of suspected functional or professional impairment involving a member of the Medical Staff. This impairment may include, but not be limited to, chemical dependency; or mental, physical or aging problems that have or could give rise to injury to a patient. The Medical Staff in so doing, attempts to fulfill its obligations to its patients; as well as its moral and professional obligations to its colleagues.

10.1.B Composition

The committee shall be composed of at least four members of the Active Staff appointed by the President of the Medical Staff. Each member is appointed for two years with no limitation on the number of terms they may serve.

The Chief Executive Officer or his designee, as well as the Chief Medical Officer, shall serve as ex officio, voting members of the committee.

This committee is established as a peer review committee, entirely independent of any other committee; and shall be entirely separate from any discipline or enforcement activities established or authorized by the Bylaws.

10.1.C Duties

Should any Medical Staff member, hospital personnel, patient or patient's family express a reasonable concern that a member of the Medical Staff is impaired, the following procedures are recommended:

(1) A written report of the specific concerns and behaviors shall be given to the Medical Director, Medical Staff President, or chairman of the Physician-In-Need (PIN) Committee. The anonymity of the individual giving the report will be maintained.

(2) If the report raises a concern that a physician may have a problem, the individual receiving the report will interview its author(s). If a concern persists following that interview, the physician involved will also be interviewed.

(3) In the case of the Acutely Impaired Physician:

(a) When hospital personnel, a patient or a patient's family expresses concern that a physician appears acutely impaired, the Nursing Supervisor must be contacted immediately. The Medical Director or his/her designee will be contacted immediately to come to the hospital.

(b) The physician in question will be informed of Hospital policy and procedure in suspected impairment and the physician will be requested to wait until the Medical director or designee arrives. At that time a urine drug screen and blood alcohol will be obtained from the physician. Every attempt will be made to follow the standard chain-of-custody procedure. The Medical Director/designee will arrange for immediate coverage for the physician's patient(s).

(c) Samples shall be submitted as John doe or director/designee's name.

(d) Should the urine screen, blood alcohol be positive, or if the Medical Director/designee determines the physician to be otherwise psychiatrically and/or physically impaired, the physician in question will be asked to cease patient care until further notice and make temporary arrangements to cover his practice.

(e) All information is to be given to the hospital Physician-In-Need Committee to be reviewed within three business days. The physician in question should be apprised of this review. The Committee shall review all information and interview the physician in question.

(4) If the initial report and/or interviews lack sufficient information to warrant further action initially, they will be kept in the physician's confidential peer review file only to be reconsidered if there is a repeat complaint.

(5) If the reports and interviews however prove substantial, the Physician-in-Need committee will be convened to review them. If the Committee concurs, it may be recommended to the physician that he/she be interviewed by the Coordinator of the Indiana State Medical Association - Physicians Assistance Program (ISMA-PAP) and that individual will be contacted.

(6) If as a result of that interview the physician is recommended to undergo a formal evaluation by a qualified facility or a qualified physician approved by the ISMA-PAP, the physician must consent to undergo the evaluation and follow the treatment recommendations that result as a condition of continued appointment and clinical privileges at Lutheran Hospital.

(7) If treatment is recommended, the physician will sign a contract with ISMA-PAP agreeing to treatment. When treatment is completed, a second long-term contract will be negotiated between ISMA-PAP and the physician which will cover but is not limited to the following:

(a) Periodic random urine screens if appropriate to the impairment.

(b) Attendance at regular Alcoholics/Narcotics Anonymous meetings if appropriate to the impairment.

(c) Attendance at Caduceus meetings appropriate to impairment.

(d) Periodic meetings with an approved physician advocate.

(e) Continued therapy as recommended by the treating physician.

(f) Other items appropriate to the impairment.

(g) Approval to send regular reports to the Medical Director documenting contract compliance.

(8) Failure to comply with the request for evaluation, recommendation for treatment, or the terms of the contract with ISMA-PAP will result in a report to the Executive Committee of the Hospital Medical Staff and possibly the Indiana Medical Licensing Board.

(9) The Medical Director, Medical Staff President, or Chairman of the Physician-in-Need Committee shall inform the individual who filed the original report that follow-up action was taken.

(10) Treatment and rehabilitation

(a) If treatment or rehabilitation is recommended to the physician, he/she will request a medical leave of absence and discontinue his/her practice in the Hospital voluntarily.

(b) If the physician refuses to discontinue practice voluntarily, his/her privileges will be immediately suspended until treatment and rehabilitation have been accomplished.

(11) Reinstatement

(a) Upon completion of program of treatment and rehabilitation as recommended by the evaluating physician/institution, the Medical Director, Medical Staff President, and Chairman of Physician-in-Need Committee may consider the physician for resumption of his clinical hospital practice.

(b) In considering an impaired physician for reinstatement, patient care interests must be paramount.

(c) A letter must be obtained from the Physician Director of the treatment/rehabilitation program where the physician was treated verifying that the physician participated in the program, was in compliance with the treatment plan, regularly attended assigned meetings, and to answer the question whether the physician is now in his/her opinion rehabilitated and capable of resuming

medical practice and providing continuous competent care to his/her patients.

(d) Periodic reports from the monitoring body (ISMA-PAP) should be reviewed by the Medical director and kept in the physician's confidential peer review file for the duration of his/her contact.

10.1.D Meetings

The committee shall meet as often as necessary to accomplish its stated purpose.

Minutes of the activities of the meeting shall not be recorded, and confidentiality will always be respected.

10.1.E Policy

The committee shall have no disciplinary powers and will act as the physician's advocate. All contacts or sources of information, to include physicians contacts, shall be held confidential.

PART XI. AMENDMENT

11.1 Amendment

This Staff Functions and Committee Manual may be amended or repealed, in whole or in part, by one of the following mechanisms:

11.1.A A resolution of the Medical Executive Committee recommendation to and adopted by the Board of trustees; or,

11.1.B A resolution of the Medical Staff and confirmed by the Executive Committee, and approved by the Board of trustees.

11.2 Responsibilities and Authority

The procedures outlined in the Bylaws and Hospital Corporate Bylaws regarding Medical Staff responsibility and authority to formulate, adopt, and recommend the Bylaws and amendments thereto, and the circumstances under which the Board of trustees may resort to its own initiative in accomplishing those functions apply as well to the formulation, adoption, and amendment of this Staff Functions and Committee Manual.

PART XII. APPROVAL

Approved by Executive Committee: June 3, 2013

Approved by Board of trustees: June 11, 2013