



Indiana University Health West Hospital

BYLAWS OF THE MEDICAL STAFF

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OF
IU HEALTH WEST HOSPITAL**

PREAMBLE

WHEREAS, IU Health West, LLC, d/b/a IU Health West Hospital (the "Hospital") is organized under the laws of the State of Indiana; and

WHEREAS, it is recognized that the members of the Medical Staff are responsible for advising the Governing Body of the Hospital on scientific and medical matters including the monitoring of health care provided within the Hospital and the credentialing and delineation of privileges for all health care providers within the Hospital, and that the members of the Medical Staff must accept and carry out such responsibility as the agents of the Governing Body in cooperation with the administration of the Hospital in order to fulfill the Hospital's obligations to its patients;

THEREFORE, the Physicians and Allied Health Care Providers practicing in this Hospital hereby organize their efforts in carrying out these tasks in conformity with these Bylaws.

DEFINITIONS

1. The term "Organized Medical Staff" includes all licensed Physicians who are privileged to attend patients in the Hospital.
2. The term "Governing Body" means the Board of Managers of the Hospital, which is the body under Indiana law which is the supreme authority in the Hospital responsible for the management, operation, functioning and control of the Hospital and appointment of and delineation of privileges for all Practitioners within the Hospital.
3. The term "Executive Committee" means the Executive Committee of the Medical Staff.
4. The term "Chief Executive Officer" or "administrator" means the individual appointed by the Governing Body to act in its behalf and the overall management of the Hospital.
5. The term "Practitioner" includes all members of the Medical Staff as a group and also includes Allied Health Care Providers as well.
6. The term "Chief of Staff" means the member of the Medical Staff elected as the chief administrative officer of the Medical Staff as more particularly described in Article XI of these Bylaws.
7. The term "Allied Health Care Provider" means all individually licensed health care providers who are not employees of the Hospital and who may qualify to exercise specified privileges within the Hospital but who are not allowed to admit patients. The term includes, but is not limited to, psychologists, certified registered nurse anesthetists, nurse midwives, physician's assistants, nurse practitioners, clinical nurse specialists, optometrists, speech pathologists, audiologists, and physical therapists. Allied Health Care Providers also include "Supervised Allied Health Practitioners," such as registered nurses, licensed practical nurses or technicians, who are employed by Medical Staff members and provide patient care services

within a IU Health Partners, Inc. facility under direct supervision of the Medical Staff member. Allied Health Care Providers are governed by these Bylaws but are not members of the Medical Staff.

8. The term “Medical Assistants” means advanced practice nurses, physician’s assistants and other persons who may provide specified health care, such as evaluations, examinations and treatments that would traditionally fall within the practice of a Physician member of the Medical Staff. Medical Assistants shall be regarded as a sub-category of Allied Health Care Providers.
9. The term “Dentist” means a doctor of dental surgery or medical surgery legally authorized to practice dentistry in the State of Indiana.
10. The term “Peer Review Committee” means the Governing Body, the Medical Staff Executive Committee, the Credentials Committee and any other committee of the Governing Body or the Medical Staff which:
 - a) recommends or takes actions based on the competence or professional conduct of an individual Practitioner that affects or may affect adversely a Medical Staff member’s clinical privileges or membership; or
 - b) has any other responsibilities as set forth in the Health Care Quality Improvement Act and the Indiana State Peer Review Act.
11. The term “Peer Review Action” means any action, recommendation or decision of a Peer Review Committee which is taken or made in the conduct of peer review activity, which is based on the competence or professional conduct of an individual Practitioner (which conduct affects or could affect adversely any individual or the health or welfare of a patient) and which affects (or may affect) adversely the clinical privileges of the Practitioner.
12. The term “Physician” means (a) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State of Indiana (including a physician within the meaning of section 1101(a)(7) of the Social Security Act (the “Act”)), or (b) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State of Indiana and who is acting within the scope of his license when he performs such functions, or (c) a doctor of podiatric medicine who is legally authorized to practice podiatry by the State of Indiana and who is acting within the scope of his license when he performs such functions, or such other meaning as is given from time to time to these professional categories by the Centers for Medicare & Medicaid Services (CMS) in its “Glossary” chapter of the Comprehensive Accreditation Manual for Hospitals.

ARTICLE I: NAME

The name of this organization shall be the Medical Staff of IU Health West Hospital.

ARTICLE II: PURPOSES

The purposes of this organization are:

1. To carry out the function of peer review as the agents of the Governing Body by reviewing the credentials of all persons who wish to provide health care to patients

of the Hospital (other than the employees of the Hospital), to recommend specific delineation of privileges for each such individual to the Governing Body, to conduct outcome oriented performance evaluations of its members and to monitor the quality of patient care and safety within the Hospital;

2. To carry out the function of continuing education by providing an appropriate educational setting for the review of scientific standards and advancements in the provision of health care.
3. To provide for organization and representation of the Practitioners who offer patient care at the Hospital in carrying out these functions, in representing the Practitioners to the Governing Body and to the community, and in planning for the future.

ARTICLE III: MEDICAL STAFF AND ALLIED HEALTH CARE PROVIDERS MEMBERSHIP

Section I: Nature of Medical Staff and Allied Health Care Provider Membership

Appointment to the Medical Staff or as an Allied Health Care Provider at the Hospital is a privilege that may be extended by the Governing Body only to professionally competent, fully licensed Physicians and Allied Health Care Providers who are permitted by law and the Hospital to provide patient care services independently and who continuously meet the qualifications, standards and requirements set forth in these Bylaws. It is the duty of the Medical Staff as the agents of the Governing Body to examine the credentials of all persons who wish to be granted privileges as members of the Medical Staff or as Allied Health Care Providers and to recommend to the Governing Body specific delineation of privileges as may be appropriate. It is the duty of each individual member of the Medical Staff or Allied Health Care Provider continuously to maintain and continuously demonstrate the appropriate level of competence, skill, training and aptitude which would justify the continuance of those privileges if granted. The failure of any Practitioner to demonstrate the requisite level of skill, health and cooperative attitude in providing patient care will necessitate the conditioning, suspension or termination of any privileges which that Practitioner may have been granted.

Students and residents shall not be regarded as either members of the Medical Staff or Allied Health Care Providers. Issues of quality assurance concerning students and residents shall be within the purview of the Medical Staff, to the extent necessary to protect the health and safety of patients, but such matters shall generally be governed by the training programs in which such students and/or residents are participating.

Section II: Qualification for Membership on the Medical Staff

- A. **General Qualifications.** The medical staff makes recommendations to the governing body for each candidate for medical staff membership/privileges that are specific to type of appointment and extent of the individual practitioner's specific clinical privileges, and then the governing body takes final appropriate action. Physicians must meet the following general criteria to qualify for appointment to the Medical Staff:
 1. Hold a valid unrestricted licensed to practice in the State of Indiana;
 2. Maintain a practice within a reasonable distance of the Hospital, so as to provide continuity and quality care, which distance may vary depending upon the specialty of the member and nature of the privileges;

3. Maintain status as a "qualified health care provider" as defined by the Indiana Medical Malpractice Act (the "Act") and maintain professional liability insurance in the amounts required by the Act;
4. Be board certified or board eligible (as defined by the applicable board) by one or more boards of the American Board of Medical Specialties or one or more boards generally recognized by the American Medical Association, American Osteopathic Association, or American Dental Association (Board certifications received in other countries (e.g., United Kingdom or Canada) may be considered equivalent to the above, and shall be reviewed on a case-by-case basis). In exceptional cases, an experienced Physician without board certification may be allowed to become a member of the Medical Staff if the individual possesses comparable competence and is widely recognized as having exceptional or special skills. However, the requirement for board certification or board eligibility shall apply to all persons who apply for membership after the first date the Hospital provides patient care services;
5. Provide evidence of relevant training and experience, current competence and ability to perform the clinical privileges requested.

No Physician shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he or she is duly licensed to practice medicine in this or in any other state, or that he or she is a member of any professional organization, or that he or she had in the past or presently has any such privileges at this or another hospital. No decisions on staff membership or privileges will be influenced by an applicant's race, creed, color, sex, or national origin, or any other criterion lacking professional justification.

B. Basic Responsibilities. The ongoing responsibilities of each member of the Medical Staff include:

1. Providing patients with the quality of care meeting the professional standards of the Medical Staff;
2. Abiding by the Medical Staff Bylaws, Rules and Regulations;
3. Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;
4. Preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the Hospital;
5. Abiding by the principles of the Code of Ethics of the American Medical Association, the American Osteopathic Association or the American Dental Society, as appropriate;
6. Aiding in any Medical Staff approved or supported educational programs for medical students, interns, resident physicians, resident dentists, staff Physicians, nurses and other personnel;

7. Working cooperatively with other staff, nurses, Hospital administration and others so as not to affect adversely patient care or the operation of the Hospital;
 8. Making appropriate arrangements as determined by the Medical Staff for coverage for the member's patients;
 9. Refusing to engage in improper inducements for patient referrals;
 10. Participating in continuing education programs as determined Medical Staff;
 11. Participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff;
 12. Immediately notifying the Medical Staff Office and the Hospital administration of any circumstances involving the following, excluding suspensions of less than seven days or lesser actions resulting from the failure to complete medical records: a) suspension or any action (censure, reprimand, and/or fine) regarding their professional license; b) loss, suspension or other actions (excludes routine renewal) regarding state or federal prescribing of controlled substances; c) loss, suspension or limitation (excludes routine non-renewal) of clinical privileges at another health care facility; d) filing of notice of exclusion/debarment from any federal health care program including Medicare/Medicaid; e) filing of any criminal charge by state or federal authorities (excludes minor motor vehicle accident);
 13. Participating in and cooperating with Medical Staff performance improvement activities; and
 14. Discharging such other Medical Staff obligations as may be established in accordance with these Bylaws and Rules and Regulations.
- C. **Hold-Harmless Agreement.** The submission of an Application for and/or acceptance of membership on the Medical Staff shall constitute an agreement to authorize the members of the Medical Staff as agents of the Governing Body to inquire and to gather any and all information concerning the applicant and/or staff member with regard to his or her qualifications to exercise privileges in the Hospital, shall constitute an authorization to any and all persons and organizations to release such information to the Governing Body, its agents and/or employees and shall constitute an agreement to release and hold harmless all persons, organizations, including the Governing Body, its agents and employees and all others who participate in good faith in providing such information regarding the applicant and/or staff member.

Section III: Qualifications for Allied Health Care Providers

- A. **General Qualifications.** Psychologists, certified registered nurse anesthetists, nurse midwives, physician's assistants, nurse practitioners, clinical nurse specialists, optometrists, speech pathologists, audiologists, physical therapists and/or Supervised Allied Health Practitioners must meet the following general criteria to qualify for privileges as Allied Health Care Providers
- (a) Hold a valid unrestricted licensed to practice in the State of Indiana.

- (b) Maintain a practice within a reasonable distance of the Hospital, so as to provide continuity and quality care, which distance may vary depending upon the specialty of the member and nature of the privileges.
- (c) Maintain status as a "qualified health care provider" as defined by the Indiana Medical Malpractice Act (the "Act") and maintain professional liability insurance in the amounts required by the Act.
- (d) Provide evidence of relevant training and experience, current competence and ability to perform the clinical privileges requested, and satisfaction of any other requirements of state law and regulations applicable to the specialty.

No such Allied Health Care Provider shall be entitled to exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he or she is duly licensed to practice in this or in any other state, or that he or she is a member of any professional organization, or that he or she had in the past or presently has any such privileges at this or another hospital. No decisions on privileges will be influenced by an applicant's race, creed, color, sex, or national origin, or any other criterion lacking professional justification.

- B. **Obligations.** Application for and/or acceptance of privileges as an Allied Health Care Provider shall constitute the provider's agreement that he or she will strictly abide by the code of ethics which governs his or her professional organization and by all of the terms and provisions of these Bylaws as they now exist or hereafter shall be amended.
- C. **Hold-Harmless Agreement.** Application for and/or acceptance of privileges as an Allied Health Care Provider shall constitute an agreement to authorize the members of the Medical Staff as agents of the Governing Body to inquire and to gather any and all information concerning the applicant and/or provider with regard to his or her qualifications to exercise privileges in the Hospital, shall constitute an authorization to any and all persons and organizations to release such information to the Governing Body, its agents, and/or employees and shall constitute an agreement to release and hold harmless all persons, organizations, including the Governing Body, its agents, and employees and all others who participate in good faith in providing such information regarding the applicant and/or staff member.

Section IV: Conditions and Duration of Appointment

- A. **Action by Governing Body.** Initial appointments and reappointments and the granting of privileges to the Medical Staff and Allied Health Care Providers shall be made by the Governing Body. The Medical Staff in assessing the credentials of initial applicants and applicants for reappointment shall act only as the agents of the Governing Body and shall make recommendations to the Governing Body concerning the granting of Medical Staff membership or appointment as an Allied Health Care Provider and shall also recommend a delineation of specific privileges for each individual. The Governing Body shall act on revocation or appointments after there has been a recommendations from the Medical Staff as provided in these Bylaws or after the Governing Body, has after notification to the Medical Staff, determined that the staff has failed to act in a timely manner. The Governing Body is acting upon these recommendations as the ultimate Peer Review Committee of the Hospital.
- B. **Application Process.** Application shall be made on an application form to be furnished by the Hospital. The burden of providing complete and sufficient evidence properly to assess such an application shall always be on the applicant or reapplicant, and no consideration

will be given to application or reapplication which is materially incomplete. The time-tables for action upon applications and reapplications are set forth in these Bylaws under the procedures for application, but it shall be understood throughout these Bylaws that the specifications of deadlines for action to be taken in any application process or corrective action proceeding shall be goals subject to good faith compliance and any failure to comply with any such deadlines after good faith efforts have been made shall not give rise to any rights or causes or action deriving from these Bylaws. The Hospital and Medical Staff may chose to enter into one or more contracts with other entities to provide some application processing services.

- C. **Bylaws are not a contract.** These Bylaws shall not be deemed as a contract of any kind. The conditions and duration of appointment to the Medical Staff or the granting of privileges as an Allied Health Care Provider shall not be deemed contractual in nature.

- D. **Term.** Initial appointments to the Medical Staff or as an Allied Health Care Provider shall be for a provisional period of six (6) months during which time the initial appointee shall be subject to close monitoring and supervision by the members of the Medical Staff and during which time the modification, alteration, or conditioning of his or her privileges will be subject to summary action. Immediately following this initial period of probationary appointment, the Medical Staff member and/or Allied Health Care Provider may be reappointed to the Medical Staff or granted privileges as an Allied Health Care Provider until the next regularly scheduled time for evaluation of reapplications for privileges. Thereafter, reappointment shall be for a period of not more than two (2) Medical Staff years. For the purpose of these Bylaws, the Medical Staff year commences on the 1st day of February and ends on the 31st day of January each year.

Notwithstanding the foregoing, for any Practitioner whose medical staff privileges are exercised solely through a contractual arrangement with the Hospital (e.g., a physician member of a medical group that holds an exclusive contract to provide services in the Hospital) his or her term of membership shall terminate on the date such contractual relationship terminates, whether by termination of the contract or termination of such Practitioner's relationship with the entity that holds such contract. Such termination shall not create any rights to a fair hearing or appellate review, unless directly due to the Practitioner's competence or professional conduct.

- E. **Acknowledgment of Obligations.** Every application for appointment to the Medical Staff or for the granting of privileges as an Allied Health Care Provider shall be signed by the applicant, shall contain the applicant's specific acknowledgement of every Medical Staff member's and Allied Health Care Provider's obligations to provide continuous care and supervision of his or her patients, to abide by the Medical Staff Bylaws, Rules and Regulations as they exist at the time of application and as they may thereafter be amended, to accept such committee assignments as may be required, to accept consultation assignments and to participate in the educational programs of the staff and Hospital. The application shall also state the applicant's obligation to demonstrate on request his or her continuing qualification to exercise specific privileges, to demonstrate by appropriate examination or testing his or her physical, mental and emotional competence on request and to provide proof of continuous professional liability insurance to qualify the Practitioner as a health care provider under the Indiana Patient's Compensation Act.

- F. **Statement of Release and Immunity from Liability.** To the fullest extent permitted by law, the applicant releases from civil liabilities the Governing Body, and all authorized

representatives of the Hospital including its Medical Staff for any acts, communications, reports, recommendations, or disclosures performed, made or received in good faith, concerning activities related to:

1. Application for appointment of clinical privileges, including temporary privileges;
 2. Periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;
 3. Proceedings for suspension of clinical privileges or revocation of staff membership;
 4. Summary suspension;
 5. All actions affecting the privileges or status of a Medical Staff member and the hearings and appellate review procedures relating thereto;
 6. Other Hospital, department, or committee activities conducted under Hospital auspices relating to the quality of patient care or the professional conduct of a Physician;
 7. Release of information to Peer Review Committees or other entities or institutions authorized to receive such information.
- G. **Medical Records.** The medical histories and physical examinations related to patient care services delivered at Hospital shall be completed and documented by a Physician or other qualified licensed individual in accordance with State law and the Hospital's policies, including the Rules and Regulations, as may be amended from time to time.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

Section I: The Medical Staff

The Medical Staff shall be subdivided into the following categories. The Medical Staff shall consist of Active Staff, Courtesy Staff, Limited Service Staff and Honorary Staff and Affiliate Staff. All initial appointments to any Medical Staff category shall be probationary for a period of six (6) months, and lifting of probationary restriction shall be considered at the time.

Section II: The Active Medical Staff

The Active Medical Staff shall consist of Physicians who regularly admit patients to the Hospital, who are located closely enough to the Hospital to provide continuous care to their patients, and who assume all of the functions and responsibilities of membership on the Active Medical Staff, including where appropriate, on-call responsibility, emergency care and consultation assignments. Members of the Active Medical Staff shall be eligible to vote, to hold office, and to serve on Medical Staff committees and shall be required to attend Medical Staff meetings.

Section III: The Courtesy Medical Staff

The Courtesy Medical Staff shall consist of Physicians qualified for staff membership, but who only occasionally admit patients to the Hospital or act only as consultants. Courtesy Medical Staff members shall not be eligible to vote or hold office in this Medical Staff organization. They shall be eligible for appointment to Medical Staff committee and to participate in the educational programs of the staff and Hospital but not to serve as chairmen of committees. Courtesy Medical Staff members who have 20 or more patient contacts in the Medical Staff year must apply for a transfer to Active Medical Staff membership. Patient contacts are defined as inpatient admissions,

inpatient consultations, outpatient surgery patients and overnight observation admissions. Attendance at Medical Staff meetings is optional for Courtesy Medical Staff members.

Section IV: Limited Service Staff

Limited Service Staff shall consist of Physicians who do not qualify for Active or Courtesy Medical Staff membership, but who have a contractual arrangement with the Hospital to provide a limited scope of services, usually under parameters defined in such contract. Examples of Limited Service Staff may include (i) locum tenens physicians, and (ii) moonlighting residents or fellows providing services in the Hospital for which they are qualified, but outside the scope of their training programs. Limited Service Staff need not be board eligible if they are residents or fellows who do not satisfy board eligibility requirements due to the status of their training program.

Limited Service Staff members shall not be eligible to vote or hold office or serve on committees in the Medical Staff organization. They shall be eligible to participate in the educational programs of the staff.

Section V: The Honorary Medical Staff

The Honorary Medical Staff shall consist of Physicians who are not active in the Hospital or who are honored by emeritus positions. These may be Physicians who have retired from active Hospital practice or who are of outstanding reputation, not necessarily residing in the community. Honorary Medical Staff member shall not be eligible to vote, to hold office, or to serve on standing Medical Staff committees or to admit patients to the Hospital or to do consultations in the Hospital.

Section VI: Affiliate Staff

The Affiliate Staff shall consist of Physicians qualified for staff membership but who do not admit or provide consultation on patients in the Hospital. Affiliate Staff Physicians are not granted privileges and do not attend to patients in the Hospital. Affiliate Staff may visit their patients when hospitalized and review their medical records, but may not write orders or make medical records entries or actively participate in the provision or management or care to patients in the Hospital. Affiliate Staff may refer patients to members of the Active Medical Staff, Courtesy Medical Staff or other medical staff categories who have privileges in the Hospital, and may refer patients or specimens for use of the Hospital's diagnostic and laboratory services. Physicians who have an ownership in the Hospital (either directly or indirectly through an entity) may not be assigned to the Affiliate Staff category.

Appointees to this category shall be required to pay application fees, staff dues and assessments. Affiliate Staff may attend Medical Staff meetings but shall not be eligible to vote and have no staff committee responsibilities, but may be assigned to special committees (with vote). They may attend educational programs of the Medical Staff.

ARTICLE V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section I: Application for Appointment

- A. All applications for appointment to the Medical Staff or for appointment as an Allied Health Care Provider shall be in writing, shall be signed by the applicant, and shall be submitted on the approved form. The application shall require, among other things, evidence of current medical license, residency training, experience at other hospitals, and satisfaction of requirements for being a qualified provider under the Indiana Medical Malpractice Act. The application shall also include any involvement in professional liability actions, at a minimum, final judgments or settlements. The application shall require detailed information concerning the applicant's professional qualifications including

undergraduate and graduate education, training and experience. The application shall include the names of at least three (3) persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character as well as the applicant's abilities to perform specific procedures or services. The personal references must also include well-founded opinions as to the applicant's ethical character and ability to work cooperatively with others in the provision of health care. The application shall also include information as to whether the applicant's membership status and/or clinical privileges have ever been subjected to the disciplinary action, revoked, suspended, reduced, not renewed or voluntarily or involuntarily relinquished at any other hospital or institution and as to whether his or her membership in local, state, or national medical professional societies or his or her license to practice any profession in any jurisdiction have ever been subjected to disciplinary action, suspended, terminated or voluntarily or involuntarily relinquished. The application shall provide further that upon request the applicant shall be obligated to provide proof by examination or testing as appropriate of his or her physical, mental or emotional health. The form shall require proof that the applicant is a qualified health care provider under the Indiana Medical Malpractice Act, or, if the applicant is not eligible by law to become a qualified health care provider, the applicant shall present proof of professional liability insurance that is determined by the Executive Committee to be adequate. The application shall contain a specific list of privileges requested. A photograph of the applicant and results of current TB test shall also be included with the application. The application form shall set forth the authorization for release of information and hold-harmless agreement contained in these Bylaws.

- B. The applicant shall have the burden of producing adequate information for a proper evaluation of his or her competence, character, ethics, physical, mental and emotional health, and other qualifications and for resolving any doubts about such qualifications.
- C. No action shall be taken upon any application or reapplication until it is materially complete. If the medical staff office is unable to obtain any of the information which is pertinent, the applicant shall be notified, and the applicant shall have the burden of obtaining the required information. The completed applications shall be submitted by the medical staff office to the Credentials Committee.
- D. By applying for appointment to the Medical Staff or as an Allied Health Care Provider, each applicant thereby signifies his or her willingness to appear for interviews in regard to his or her application, authorizes the Hospital to consult with members of the medical staffs of other hospitals with which the applicant has been associated, and with others who may have information bearing on his or her competence, health, character and ethical qualifications; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his or her professional qualifications, training, health, and competence to carry out the clinical privileges he or she requests as well as of his or her moral and ethical qualifications for staff membership; authorizes all persons who may have such information to communicate it to the Governing Body, its agents or employees; releases from liability all representatives of the Hospital and members of the Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his or her credentials, and releases from any liability all individuals and organizations, including the Governing Body, its agents, and employees, who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for staff appointment and clinical privileges, including otherwise privileges or confidential information.

- E. The application form shall include a statement that the applicant has received and read the Bylaws of the Hospital Governing Body and the Bylaws and Rules and Regulations of the Medical Staff, and a statement that he or she agrees to be bound by the terms thereof if he or she is granted membership and/or clinical privileges in all matters relating to consideration of his or her application.

Section II: Appointment Process

- A. The medical staff office shall transmit the completed application to the Chairman of the Department for which the Practitioner is seeking privileges. The Chairman shall review all relevant materials and make a recommendation to the Credentials Committee. The Credentials Committee shall review the application, along with the Department Chairman's recommendation and shall make a written report of its investigation to the Executive Committee, including its recommendation that the Practitioner be appointed as a member of the Medical Staff or as an Allied Health Care Provider, that he or she be rejected for Medical Staff membership or appointment as an Allied Health Care Provider, or that his or her application be deferred for further consideration. All recommendations for appointment must also specifically delineate which clinical privileges shall be probationary in nature. (A completed application is one for which all required information has been received and verified with primary sources whenever possible.)
- B. Prior to making this report and recommendation, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications, and ethical standing of the Practitioner and shall determine, through information contained in references given by the Practitioner and from other sources available to the committee, whether the Practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by him or her including an evaluation of the applicant's physical and mental health. The Credentials Committee shall obtain the written opinion of a Practitioner in the same specialty as the applicant as to the applicant's credentials and qualifications for the specific privileges requested. The Credentials Committee shall transmit to the Executive Committee the completed application and all other documentation considered in arriving at its recommendation, subject to the applicant's right to request an ad hoc hearing and appeal concerning any denial of application or of specific privileges.
- C. When the written recommendations of the Credentials Committee is to defer the application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for appointment with specified clinical privileges or for rejection of the application. Provided, however, the Credentials Committee may further defer action if necessary to obtain a reply from the National Practitioner Data Bank.
- D. When the recommendation of the Credentials Committee is adverse to the Practitioner, either in respect to appointment or to specific clinical privileges, the Chief Executive Officer shall promptly so notify the Practitioner by certified mail, return receipt requested. No such adverse recommendation shall be forwarded to the Governing Body until after the Practitioner has exercised or has been deemed to have waived his or her right to a hearing as provided in Article IX of these Bylaws. If the Practitioner waives or is deemed to have waived his or her right to a hearing, the report of the Executive Committee shall be forwarded to the Governing Body for appropriate action. If the Practitioner elects to exercise his or her right to a hearing, all further proceedings shall be governed by Article IX of these Bylaws. The fact that the adverse decision is being held in abeyance shall not be

deemed to confer privileges where none existed before or to provide any basis for the continuance of temporary privileges.

- E. At the next regular or specially called meeting of the Governing Body after receipt of a favorable recommendation from the Executive Committee, the Governing Body shall act in the matter. If the Governing Body's decision is adverse to the Practitioner in respect to either appointment or clinical privileges, and if the Practitioner has not previously been offered the right to a hearing, the Chief Executive Officer shall promptly notify him or her of such adverse recommendation by certified mail return receipt requested and such adverse recommendation shall be held in abeyance until the Practitioner has exercised or has been deemed to have waived his or her right under Article IX of these Bylaws and until there has been a consideration of the matter by the Joint Liaison Committee of the Governing Body and Medical Staff. The fact that the adverse decision is being held in abeyance shall not be deemed to confer privileges where none existed before or to provide any basis for the continuance of temporary privileges.
- F. At its next regular or specially called meeting after all of the Practitioner's rights under Article IX have been exhausted or waived, the Governing Body or its duly authorized committee shall act in the matter. The Governing Body's decision shall be conclusive, except that the Governing Body may refer the matter back to the Executive Committee for specified further investigation, setting a deadline for action and specifying exactly what additional information is required. After receipt of such additional information, the Governing Body shall act in the matter.
- G. Whenever the Governing Body's decision will be contrary to the recommendation of the Executive Committee, the Governing Body shall submit the matter to the Joint Liaison Committee for review and recommendation and shall consider such recommendation before making its final decision. The Governing Body shall, however, not be bound by any recommendation of the Joint Liaison Committee.
- H. When the Governing Body's decision is final, it shall send notice of such decision through the Chief Executive Officer to the applicant and the Executive Committee by certified mail, return receipt requested.

Section III: Reappointment Process

- A. All requests for reappointment to the Medical Staff or for appointment as an Allied Health Care Provider shall be in writing, shall be signed by the applicant, and shall be submitted every other year in writing on the appropriate forms. Applications for reappointment shall specify exactly which clinical privileges are being requested. No reapplicant will be granted privileges solely because he or she has exercised such privileges in the past at this Hospital or at any other hospital. Results of annual TB test must be submitted with completed application for reappointment as condition to continue to practice in the Hospital.
- B. Upon receipt of the completed application for reappointment, the medical staff office shall obtain any additional information required under applicable policies, and shall transmit the application and supporting documents to the Chairman of the Department in which the Practitioner holds privileges. The medical staff office shall also furnish the Chairman with copies of any incident reports which are relevant to the reapplicant's exercise of Hospital privileges. The Chairman shall review all relevant materials and make a recommendation to the Credentials Committee.

- C. The Credentials Committee shall evaluate the application and supporting documents, and make an independent assessment of each and every privilege for which the applicant is applying and shall submit a written report and recommendation to the Governing Body through the Executive Committee. Prior to the writing of this report, the Credentials Committee may invite the applicant to appear before it to discuss specific privileges for which the applicant is reapplying and to solicit additional evidence as to continuing competence, training, and medical education. The Credential Committee may also request and require the applicant to submit to appropriate physical and/or mental health evaluation and/or testing.
- D. If after consultation with the applicant, the report of the Credentials Committee is adverse either in the matter of appointment to the Medical Staff or as an Allied Health Care Provider or as to specific clinical privileges, the Chief Executive Officer shall notify the applicant by certified mail return receipt requested, and the applicant shall exercise or waive his or her rights to a hearing and appeal as specified in Article IX. Thereafter, the procedure to be followed on reapplication shall be the same specified above for initial applications.
- E. Recommendations for reappointment and the granting of privileges shall be based upon assessment of the particular candidate's proven continuing professional skills, demonstrated clinical judgment, level of performance, ethical conduct, attendance, participation and dedication to staff affairs, compliance with Hospital and Medical Staff Bylaws, Rules and Regulations, cooperation with other Hospital personnel, use of conferred privileges in an efficient manner consistent with the financial well being of the Hospital, relations with patients, colleagues, the public, and Governing Body, and the applicant's physical and mental health. A Practitioner's clinical privileges may be reduced or modified, and a Medical Staff Member's category of membership may be changed if there has been insufficient clinical activity on which to evaluate continuing professional skills, judgment or other factors bearing on the reappointment decision.

ARTICLE VI: CLINICAL PRIVILEGES

Section I: Requests for Privileges.

Every initial application and reapplication shall include a specific request by the applicant and re-applicant for the privileges which he or she wishes to exercise. Practitioners may apply for additional privileges at any time during a Medical Staff year by making special application for additional privileges which shall be handled as an initial application for privileges as set forth in Article V.

Section II: Clinical Privileges Restrictions.

- A. Restrictions. Every Practitioner practicing at this Hospital by virtue of Medical Staff membership or as an Allied Health Care Provider shall in connection with such practice be entitled to exercise only those specifically granted to him or her by the Governing Body except as provided in these Bylaws for temporary privileges and emergency privileges.
- B. Allied Health Care Provider Privileges. Privileges granted to Allied Health Care Providers shall be based upon their training, experience, and demonstrated competence and judgment. A Physician member of the Medical Staff shall be responsible for the initial

history and physical examination and assessment of the patient's medical condition at the time of admission and shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during Hospitalization. A history and physical ("H&P") must be completed and documented for each patient no more than 30 days prior to or 24 hours after hospital admission or registration, but prior to surgery or a procedure requiring anesthesia services. The H&P may be handwritten or transcribed, but always must be placed within the patient's medical record within 24 hours of admission or registration, or prior to surgery or a procedure requiring anesthesia services. The responsible Medical Staff member may delegate certain patient care duties to other authorized personnel, but such delegation shall not release the Medical Staff member from ultimate responsibility as described above. Allied Health Care Providers may not admit patients without the concurrence and co-admission of a Physician member of the Medical Staff.

C. Responsibility of Co-Admitting Physicians, Allied Health Care Providers and Podiatrists.

- (a) A Physician member of the Medical Staff who co-admits a patient with an Allied Health Care Provider does not thereby accept responsibility for the Practitioner's care afforded to that patient. The responsibility of a co-admitting Physician shall be to supervise and monitor the medical care of the patient other than the specific procedures, evaluation, or counseling which are to be performed.
- (b) Podiatrists shall co-admit and co-manage patients to the health system for podiatric surgery with an active physician member of the Medical Staff. The physician shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. All podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. The podiatrist is responsible for the part of the history and examination related to podiatric care.

Section III: Temporary Privileges.

Before a Practitioner practices within a Hospital setting, a review of all completed information regarding qualifications and skills of the applicant shall be performed. This shall include verification of training/experience from all of those sources listed in the application, verification of current licensure, competence and ability to perform the privileges requested. Temporary privileges may be granted for only the following circumstances: to fulfill an important patient care need, i.e. a Physician becomes ill or takes leave of absence; a visiting Physician; or the applicant with a complete, application is waiting review and approval of the Executive Committee and the Governing Body.

- A. **Privileging Requirements.** Temporary privileges may be considered from a requesting applicant AFTER the following criteria are met: All required applicant documentation has been received from the requesting Practitioner; all items requiring verification have been verified; the Department Chairman has recommended approval of the application; and there are no questions concerning the qualifications for privileges by the Credentials Committee Chairperson, Chief of the Medical Staff and Chief Executive Officer of the Hospital.

Temporary privileges may be granted by Chief of Staff and the Chief Executive Officer, acting as agents of the Governing Body.

- B. **Duration.** If there are no questions concerning the applicant's qualifications, temporary privileges granted in this manner shall remain in effect until approved at the next

Executive Committee meeting, but not to exceed 120 days. If a question about the applicant's qualifications should arise after temporary privileges have been granted, the applicant's temporary privileges will be revoked. The termination of an applicant's temporary privileges shall not create any rights to a fair hearing or appellate review.

Section IV: Emergency Privileges.

In the case of some natural catastrophe, local or national emergency, or other emergency, any Physician who is presently treating an emergency patient or has initiated therapy may continue such therapy upon arrival at the Hospital and continue to do so and be assisted to do everything possible to save the life of the patient using every facility of the Hospital necessary including the calling of any consultation necessary. Allowing such a Practitioner to render care to a patient shall not extend beyond the immediate need for such emergency care and shall give rise to no rights under these Bylaws.

Section V: Delineation of Privileges.

The Practitioner shall have the burden of establishing his/her qualifications and competency in the clinical privileges for which he/she is initially applying or reapplying. At a minimum, Physicians (excluding Dentists and Podiatrists) seeking privileges must establish the following:

- A. Graduation from an accredited medical school and completion of at least a one (1) year internship in a Hospital maintaining such standards as: (i) would comply with the requirements for accreditation for intern training by the American Medical Association or the American Osteopathic Association; and (ii) as would comply with the appropriate American specialty board, as determined by the Credentials Committee and subject to approval by the Governing Body; and
- B. Certification by the appropriate American specialty board (or board eligibility as defined by such specialty board), as determined by the Credentials Committee and subject to approval by the Governing Body.

At a minimum, Dentists, Podiatrists and Allied Health Practitioners seeking privileges must establish the following:

- A. Graduation from an accredited professional school appropriate for the privileges applied for by the Practitioner, such appropriateness to be determined by the Credentials Committee, subject to approval by the Governing Body; and completion of sufficient postgraduate training and/or experience as deemed appropriate by the Credentials Committee, subject to approval by the Governing Body.
- B. Certification by the appropriate American specialty board if board certification is available in the specialty for which the applying Practitioner is seeking privileges, as determined by the Credentials Committee and subject to approval by the Governing Body.
- C. A Practitioner can satisfy the requirements in B. above by establishing that his/her qualifications are the equivalent of certification by the appropriate American specialty board. Such formal training and/or experience of specific duration as determined by the Credentials Committee, subject to approval of the Governing Body.
- D. If board certification is not available in a specialty for which an applying Practitioner is seeking privileges, then the Credentials Committee, subject to approval by the Governing Body, shall establish, in writing, relevant minimum qualifications which shall be applied

equally to all Practitioners applying for privileges in such specialty. Such minimum qualifications shall require Practitioners obtaining privileges for such a specialty to have a high level of training and/or experience and competency as required by the nature of the specialty, as determined by the Credentials Committee and subject to approval by the Governing Body.

The Credentials Committee shall have the discretion to require additional documentation in cases where the nature and/or scope of an applicant's training is in question.

ARTICLE VII: ALLIED HEALTH CARE PROVIDERS

Section I: Professionals Who May Qualify As Allied Health Care Providers

Qualifications for Allied Health Care Providers are set forth in Article III, Section III. Such persons shall be governed by these Bylaws and shall be subject to the credentialing and peer review functions of the Medical Staff but shall not be considered members of the Medical Staff, shall have no vote in Medical Staff elections or deliberations, and are not required to attend Medical Staff meetings or to serve on any committees. Since the Hospital is organized and functions under a theory of medicine which is mutually intelligible by medical doctors, doctors of osteopathy, Dentists, and podiatrists but which is not congruent with the theory of chiropractic or acupuncture, chiropractors and non-Physician acupuncturists shall not be considered for Medical Staff membership or for privileges as Allied Health Care Providers.

Section II: Medical Staff Sponsors

Since no Allied Health Care Provider may admit patients to the Hospital and no Allied Health Care Provider other than psychologists can provide services to a patient in the Hospital except on the order of a Physician, applications for privileges as an Allied Health Care Provider other than psychologists must contain the name of at least one Medical Staff member who has agreed to make use of the services of the applicant as an Allied Health Care Provider within the Hospital. A Physician sponsor by signing such an application is not obligated to request the services of that Allied Health Care Provider thereafter but is obligated to supervise and review the quality of care provided by that Allied Health Care Provider written by the Medical Staff sponsor and other Medical Staff member who have requested the services of the Allied Health Care Provider.

Section III: Medical Assistants

- A. Medical Assistants shall apply for privileges on forms approved by the Credentialing Committee of the Medical Staff, subject to approval by the Governing Body. Such forms shall require the submission of information concerning the applicant's education, training, experience, good character, health, ethics, and the specific privileges which the Medical Assistant is requesting. The Medical Staff shall establish a delineation of privileges for, but not limited to, physician's assistants and advanced practice nurses (including nurse practitioners, clinical nurse specialists, and certified nurse midwives) who are health care professionals licensed in the State of Indiana with Physician sponsorship and supervision. The procedure for evaluating and appointing the Medical Assistant shall be the same as provided for members of the Medical Staff. Medical Assistants must have a contract with a supervising Physician on the Medical Staff, which contract meets all requirements of applicable law. The appointment and privileges granted to a Medical Assistant will expire at the same time as his/her Physician sponsor's Medical Staff appointment and privileges expire. The procedure for reappointment for all physician extenders will be the same as set forth for members of the Medical Staff. Medical Assistants shall abide by Bylaws and Rules and Regulations of the Medical Staff.

- B. Functions delegated to Medical Assistants shall be based upon their training, experience, and demonstrated competence and judgment. All procedures performed by a Medical Assistant will be under the direction of the Physician who shall be responsible for the care of the patient.

Section IV: Supervised Allied Health Practitioners

- A. Supervised Allied Health Practitioners, such as registered nurses, licensed practical nurses and technicians employed by Medical Staff members, shall apply for privileges on forms approved by the Credentials Committee of the Medical Staff, subject to approval by the Governing Body. Such forms shall require the submission of information concerning the applicant's education, training, experience, good character, health, ethics, and the specific privileges that the applicant is requesting. A supervising Physician sponsor must also submit a sponsor letter and proposed job description for the applicant, satisfying any applicable criteria established by the Credentials Committee or Department in which the applicant proposes to work. The privileges granted to a Supervised Allied Health Practitioner will expire at the same time as his/her Physician sponsor's Medical Staff appointment and privileges expire. The procedure for reappointment for all Supervised Allied Health Practitioners will be the same as set forth for members of the Medical Staff. Supervised Allied Health Practitioner shall abide by Bylaws and Rules and Regulations of the Medical Staff.
- B. A Supervised Allied Health Practitioner may perform an act, duty or function for which the Practitioner is trained, and which is performed under the direct supervision of a Physician member of the supervising group within whose area of practice the act, duty, or function falls. A Supervised Allied Health Practitioner may not make a diagnosis or prescribe a treatment and must report the results of any examination of a patient to the supervising Physician or a Physician member of the group under whose supervision the Practitioner is working.

ARTICLE VIII: CORRECTIVE ACTION

Section I: Criteria for Initiation

Whenever the activities or professional conduct of any Practitioner with clinical privileges are, or are likely to be, detrimental to patient safety or to the delivery of quality patient care, or are reasonably probable of being disruptive to hospital operations, corrective action against such Practitioner may be initiated by any officer of the Medical Staff, by the chief or chairperson of any department or committee of the Medical Staff, by the Chief Executive Officer or by the Governing Body.

Section II: Requests and Notices

All requests for corrective action shall be stated in writing and supported by reference to the specific activities or conduct which constitute the grounds for the request and submitted to the Executive Committee. The chairperson of the Executive Committee shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the committee and shall continue to keep the Chief Executive Officer fully informed of all action taken in conjunction herewith.

Section III: Investigation by a Department

The Executive Committee shall forward the request for corrective action to the chief of the department in which the questioned activities or conduct occurred. The chief of such department shall immediately investigate the matter or appoint an ad hoc committee to investigate it. Within thirty (30) days after the receipt of the request, the department chief or the ad hoc committee shall forward a written report of the investigation to the Executive Committee. (If the Practitioner is the chief of the department, then the request for corrective action shall be given to an ad hoc committee appointed by the chairperson of the Executive Committee.)

Section IV: Executive Committee Action

Within thirty (30) days following receipt of the department or ad hoc committee report, the Executive Committee shall take action upon the request. Such action may include, without limitation:

- (a) Rejecting the request for corrective action;
- (b) Issuing a verbal warning, a letter of admonition, or a letter of reprimand;
- (c) Recommending terms of probation;
- (d) Recommending reduction, supervision or revocation of clinical privileges;
- (e) Recommending reduction of staff category or limitation of any staff prerogatives directly related to patient care;
- (f) Recommending revocation of staff membership.

Section V: Procedural Rights

All recommendations made by the Executive Committee pursuant to Section IV (d), (e), or (f), or any combination of such actions shall be referred to the Governing Body for appropriate action subject to the exercise by the Practitioner of the procedural rights afforded by Article IX and the Fair Hearing Plan appended hereto.

Section VI: Other Action

The Executive Committee's action pursuant to Section IV (a) or (b) shall be reported to the Governing Body and notice of the action given to the Practitioner as provided in the Fair Hearing Plan.

Section VII: Summary Suspension

- A. **Criteria and Initiation.** Whenever a Practitioner willfully disregards these Bylaws or other Hospital policies, or whenever his/her conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Hospital, the Chairperson of the Executive Committee (or his/her designee) with the concurrence of at least one additional elected officer of the Medical Staff, the Executive Committee of the Medical Staff or the Governing Body shall have the authority to suspend summarily the Medical Staff membership status or all or any portion of the clinical privileges of such Practitioner. Such summary suspension shall become effective

immediately upon imposition, and the Chief Executive Officer shall promptly give notice of the suspension to the Practitioner, personally and by certified mail, return receipt requested, sent to his/her office or residence. In the event such privileges are suspended, his/her patient(s) shall be assigned by the Chairperson of the Executive Committee to an appropriate member of the staff.

- B. **Executive Committee Action.** Within 72 hours after such summary suspension, a meeting of the Executive Committee shall be convened to review and consider the action taken. The Executive Committee may recommend to the Governing Body modification, continuation or termination of the terms of the summary suspension. The action recommended by the Executive Committee shall remain in effect pending a final decision by the Governing Body.

- C. **Procedural Rights.** The Practitioner who has been summarily suspended shall be entitled to the procedural rights as provided in Article IX, and the matter shall be processed in accordance with the provisions of the Fair Hearing Plan.

Section VIII: Automatic Suspension

- A. **License.** A staff member or affiliate whose license, certificate or other legal credential authorizing him/her to practice in this state is revoked or suspended shall immediately and automatically be suspended from practicing in the Hospital.

- B. **DEA Number.** A staff member whose DEA number is revoked or suspended shall immediately and automatically be suspended from practicing in the Hospital. As soon as possible after such automatic suspension, the Executive Committee shall convene to review and consider the facts under which the DEA number was revoked or suspended. The Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in its investigation. Expiration of a DEA number due to failure to process a renewal shall result in withdrawal of the Practitioner's privileges to prescribe narcotics until the renewal is in effect.

- C. **Failure to Satisfy Special Appearance Requirement.** The privileges of a Practitioner who fails to appear before a departmental or other peer review committee to discuss one or more patient cases as requested in writing, without good cause, shall immediately and automatically be suspended.

- D. **Medical Records.** An automatic suspension shall, after warning of delinquency, be imposed for failure to complete medical records in a timely fashion. Such suspension shall mean the loss of the Practitioner's admitting prerogative and of his/her clinical privileges and shall be effective until medical records are completed. For the purpose of enforcing this provision, justified reasons for delay in completing medical records shall include, without limitations:
 - (a) That the attending Physician or any other individual contributing to the record is ill, on vacation, or otherwise unavailable for a period of time, for other good cause reported to the Medical Records Department or as approved by the Chairperson of the Executive Committee.
 - (b) That the Practitioner has dictated reports and is waiting for the Hospital personnel to transcribe them.

- E. **Procedural Rights.** A Practitioner under automatic suspension by operation of Section VIII A, B, C or D shall not be entitled to the procedural rights provided in Article IX or in the Fair Hearing Plan.

Section IX: Notification of National Health Practitioner Data Bank

The Chief Executive Officer will be responsible for providing timely notification to a member of the Medical Staff whenever adverse information pertinent to that member is being reported to the National Health Practitioner Data Bank.

ARTICLE IX: FAIR HEARING AND APPELLATE REVIEW

Section I: General Provisions

- A. **Exhaustion of Remedies.** If adverse action described in Section II is taken or recommended, the applicant or member must exhaust the remedies afforded by the Medical Staff Bylaws and this Article before resorting to legal action.
- B. **Application of Terms.** For purposes of this Article, the term "member" may include "applicant" as it may be applicable under the circumstances. Additionally the term "Executive Committee" may include "Designated Committee" in those instances where a Designated Committee has been appointed to conduct the hearing.

Section II: Grounds for Hearing

Except as otherwise specified in the Bylaws, any one or more of the following actions or recommended actions shall be deemed an actual or potential substantive adverse disciplinary action and shall constitute grounds for a hearing before the Executive Committee:

- (a) denial of Medical Staff membership;
- (b) denial of requested advancement in staff membership, or category;
- (c) denial of Medical Staff reappointment;
- (d) involuntary change of Medical Staff category;
- (e) suspension of Medical Staff membership;
- (f) revocation of Medical Staff membership;
- (g) denial of requested clinical privileges (excluding temporary privileges) except where such denial is the result of a policy recommended by the Executive Committee and adopted by the Governing Body and is not related to the applicant's competence or professional conduct;
- (h) involuntary reduction of current clinical privileges except where such denial is the result of a policy recommended by the Executive Committee and adopted by the Governing Body and is not related to the applicant's competence or professional conduct;

- (i) suspension of clinical privileges except where such denial is the result of a policy recommended by the Executive Committee and adopted by the Governing Body and is not related to the applicant's competence or professional conduct;
- (j) termination of all clinical privileges; or
- (k) special limitations such as co-admission requirements or involuntary imposition of significant consultation, monitoring or preceptorship requirements (excluding monitoring incidental to provisional status).

Section III: Request for Hearing

- A. **Notice of Action or Proposed Action.** In all cases in which action has been taken by the Executive Committee or the Governing Body as set forth in Section II, the member shall be sent written notice informing him/her of the recommendation or action, the right to request a hearing pursuant to Section III and the requirement that the member's request for a hearing must be received at the Medical Staff Office within thirty (30) days after the member's receipt of the Notice of Action or Proposed Action. Notice shall be sent by certified mail to the member at the office address currently on file in the Medical Staff Office or other appropriate address.
- B. **Notice of Charges.** Together with the notice of action or proposed action, the notice shall state clearly and concisely in writing the reasons for the adverse action taken or recommended, including the acts or omissions with which the member is charged and a list of the medical charts in question, where applicable. The notice shall also advise the member of his/her rights at a hearing.
- C. **Request for Hearing.** The member shall have thirty (30) calendar days following receipt of notice of such action or recommended action to request a hearing. The request shall be in writing addressed to the Chief of the Medical Staff. In the event the member does not request a hearing within the time and in the manner prescribed, the member shall be deemed to have waived any and all right to a hearing and to have accepted the recommendation or action involved.
- D. **Time and Place for Hearing**
 - (a) Upon receipt of a request for hearing, the Executive Committee shall schedule a hearing and give notice to the member of the time, place and date of the hearing and a list of witnesses expected to testify at the hearing on behalf of the body initiating the adverse action. The date of the commencement of the hearing shall be not less than thirty (30) nor more than sixty (60) calendar days from the date of the receipt of the member's request for a hearing, except that the Executive Committee, in its discretion, may extend the commencement date of the hearing for good cause shown.
 - (b) Notwithstanding sub-section D (a), when the request is received from a member who is under summary suspension the hearing may be held prior to the expiration of thirty (30) calendar days from the date of receipt of member's request for a hearing if the parties agree in writing. If the parties do not agree to advance the date of the hearing, the time limitations set forth in D (a) shall apply.

- E. **Executive Committee Review.** The evidentiary hearing shall be conducted before the Executive Committee, except that the Chief of the Medical Staff may, in his discretion, designate an ad hoc committee (hereinafter "Designated Committee") of no fewer than three (3) members to hold the evidentiary hearing if the Chief determines that circumstances are such that the Designated Committee would provide a more appropriate forum for the hearing than would the Executive Committee. Physicians who are in direct competition with the affected member are ineligible to participate or vote as a member of the Executive Committee or Designated Committee before which the evidentiary hearing is conducted. There shall be a majority of the members of the Executive Committee or Designated Committee who are eligible to participate present when the hearing takes place and no member may vote by proxy. The decision and recommendation of a majority of the members of the Executive Committee present and entitled to vote shall constitute the decision and recommendation of the Executive Committee. If the hearing is conducted by the Designated Committee, the decision and recommendation of a majority of the members of the Designated Committee present and entitled to vote shall constitute the decision and recommendation of the Executive Committee.

- F. **Failure to Appear or Proceed.** The personal presence of the member for whom the hearing is scheduled shall be required. The member's failure without good cause to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and the member shall have been deemed to waive all rights to an evidentiary hearing.

- G. **Postponements and Extensions.** Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted by these Bylaws may be permitted by the Presiding Officer in his discretion only on a showing of good cause.

Section IV: Pre-hearing Procedure

If either side to the hearing requests in writing a list of witnesses, each party shall furnish to the other and to the Presiding Officer a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. Both parties shall exchange all written Exhibits proposed to be introduced at the hearing no later than fourteen (14) days prior to the hearing. The Presiding Officer or his representative may confer with both sides to encourage an advance mutual exchange of documents which are relevant to the issues to be presented at the hearing and to determine the projected length and scope of the hearing and to promote an efficient and orderly hearing.

Section V: Hearing Procedure

- A. **Conduct of Hearing.** The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. The hearing is for the purpose of resolving on an intra-professional basis matters bearing on professional competency and conduct. Any relevant matter on which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal actions.

- B. **Rights of the Affected Member.** The affected member shall have the following rights:
 - (a) to be represented by an attorney or other person of the affected member's choice;

- (b) to have a record of the proceedings made and to obtain a copy of the record upon payment of a reasonable charge;
 - (c) to call, examine, and cross examine witnesses;
 - (d) to present evidence determined to be relevant by the Presiding Officer; and
 - (e) to submit a written statement at the close of the hearing.
- C. **Presiding Officer.** The Chief of Staff, or in his absence the Vice Chief of Staff or in his absence the Secretary, of the Medical Staff shall preside over a hearing conducted by the Executive Committee. If the Chief of Staff and Vice Chief of Staff and Secretary are unavailable or ineligible to participate in the hearing because they are in direct economic competition with the affected member, or for any other reason, the CEO shall appoint the Presiding Officer. If the hearing is conducted by a Designated Committee, the committee shall select one (1) of its members to be the Presiding Officer. The Presiding 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 Presiding Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the Presiding Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Presiding Officer may take such discretionary action as seems warranted by the circumstances.
- D. **Presentation of Evidence**
- (a) The Chief of Staff shall designate a member of the Medical Staff or an attorney (the “designee”) to present the facts in support of the recommendation, to introduce written evidence, to examine witnesses, and to cross-examine witnesses. It is the obligation of the body initiating an adverse recommendation to present appropriate evidence in support of the adverse recommendation. The affected member shall thereafter be responsible for supporting his challenge to the adverse recommendation. The charges against the member shall be made a part of the record and any documents or other written material furnished the affected member at his request may be introduced into evidence by either party. Upon completion of the hearing a complete transcript of the proceeding shall be prepared.
 - (b) Any member of the Executive Committee, upon being recognized by the Presiding Officer, may question witnesses.
 - (c) After the affected member shall have presented his case, the designee shall have the opportunity to present appropriate evidence in rebuttal to the affected member. If the affected member does not testify in his own behalf, he may be called and examined as if under cross-examination.
 - (d) At the conclusion of the presentation of the evidence, the Presiding Officer, in his sole discretion, may permit an oral summary to be made by the participants, if it is felt that this would assist the Executive Committee in its deliberations and decision.

- (e) The Executive Committee without special notice may recess a hearing until a later date for good cause only. In the event that a hearing is bifurcated, only those council members in attendance at all hearing sessions may vote. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Executive Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the affected member.
- E. **Basis for Recommendation.** The recommendation of the Executive Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The recommendation of the Executive Committee shall be subject only to such rights of appeal or review as described herein.
- F. **Recommendation of the Executive Committee.** Within thirty (30) days after the final adjournment of the hearing, or within thirty (30) days of the receipt of the hearing transcript, whichever is later, the Executive Committee shall submit written findings, conclusions, its recommendation, and the basis for the recommendation to the Governing Body along with a record of the hearing. The report may recommend confirmation, modification or rejection of the allegations against the member, or other appropriate recommendation. The affected member shall be furnished a copy of the Executive Committee's findings, conclusions, written report and recommendation at no expense, but the member shall be required to purchase a record of the proceedings at a reasonable charge if he desires such record.
- G. **Decision of Governing Body and Appeal**
- (a) The Governing Body (acting, in its discretion, as a whole or through an appropriate standing or ad hoc committee) shall receive the report and recommendation of the Executive Committee and shall take final action thereon based upon the record made before the Executive Committee. The member shall be notified by certified mail sent to his or her last known office address on file at the Medical Staff Office or other appropriate address, at least twenty (20) days before the meeting of the Governing Body at which the recommendation of the Executive Committee is to be acted upon. Said Governing Body meeting shall be held within sixty (60) days of the Board's receipt of the report and recommendation of the Executive Committee.
- (b) If the member desires to appeal the recommendation of the Executive Committee to the Governing Body, a written request for a review of the recommendation shall be made to and received by the Chairman of the Governing Body at least seven (7) days before the Board meeting, setting forth with reasonable particularity the grounds for believing that the recommendation of the Executive Committee lacks any factual basis or is arbitrary, unreasonable or capricious. The hearing before the Governing Body shall be an appellate and not an evidentiary hearing. Failure to submit a written request for appeal to the Board within the required time limit shall constitute a waiver of the member's right to appeal the recommendation of the Executive Committee. A member who has submitted a timely appeal may be present during the Governing Body' review of the recommendation of the Executive Committee and may make an oral presentation in person or by counsel. The Executive Committee may also make an oral presentation by a representative thereof or by counsel. The Governing Body, in its discretion, may limit the amount of time for any such presentation. The Governing Body may deliberate and take action outside the presence of the affected member.

- (c) The action taken by the Governing Body may be (1) to affirm the recommendation of the Executive Committee, (2) to reverse the recommendation of the Executive Committee, or (3) to refer the recommendation back to the Executive Committee for further consideration with reasons for doing so. If the decision is to refer the matter back, the Executive Committee shall give the matter further consideration and respond to the directions of the Board and may, in its discretion, hold a further hearing or act on the record and make a further recommendation to the Governing Body, which shall thereupon, without further notice to the affected member or hearing, take final action. The final decision of the Governing Body shall be in writing and shall set forth the basis for the decision. The final written decision shall be provided to the affected member by mailing it certified mail sent to his or her last known office address on file at the Medical Staff office or other appropriate address.

- H. **Finality of Board Action.** The determination of the Governing Body shall be final with no right of appeal. No member shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any matter which has been the subject of adverse action or recommendation.

ARTICLE X: DEPARTMENTS OF THE MEDICAL STAFF

Section I: Organization of the Medical Staff Departments

Each department shall be organized as a separate part of the Medical Staff and shall have a chief who shall have the authority, duties and responsibilities as specified herein.

Section II: Designation

The clinical departments of the Medical Staff shall be as follows:

- (a) **Medicine.** It is anticipated that the Medicine Department shall have at least the following Subsections: Internal Medicine, Family Practice, Emergency Medicine, Intensive Care, Psychiatry, Radiation Oncology, Radiology, Pathology. Depending on numbers of Practitioners and volumes of medical specialty cases, additional Subsections may be organized by the Department.

- (b) **Surgery.** It is anticipated that the Surgery Department shall have at least the following Subsections: General Surgery, Anesthesiology, and Dentistry. Depending on numbers of Practitioners and volumes of surgical specialty cases, additional Subsections may be organized by the Department. The anesthesia services must be under the direction of a qualified MD/DO. The hospital's medical staff establishes criteria for the qualifications for the director of the anesthesia services in accordance with State laws and acceptable standards of practice. A single anesthesia director must be responsible for the single hospital-wide anesthesia service.

- (c) **Obstetrics-Gynecology.** Initially, it is not anticipated that Subsections will be organized. However, depending on numbers of Practitioners and volumes of cases, Subsections may be organized by the Department.

- (d) **Pediatrics**. Initially, it is not anticipated that Subsections will be organized, However, depending on numbers of Practitioners and volumes of cases, Subsections may be organized by the Department.

Section III: Assignment of Departments

The Chief of Staff shall make the initial and annual departmental assignments for all Medical Staff members based on their respective major areas of specialization and any recommendations of the Credentials Committee. All members of the Medical Staff shall be assigned to one or more of the clinical departments.

Departments may create subsections or committees to address specific needs or concerns. When such sub-groups are created, the chairperson is to be designated and members are to be appointed by the departmental chief.

Section IV: Functions of Departments

The primary responsibility delegated to each clinical department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the clinical department. To carry out this responsibility the following activities shall be conducted:

- (a) Establish guidelines for granting of clinical privileges, consistent with the policies of the Medical Staff and the Governing Body and submit recommendations for privileges in individual cases.
- (b) Retrospective review of completed records of discharged patients, and other pertinent sources of medical information relating to patient care.
- (c) Monitor on a continuing and concurrent basis adherence to:
 - (1) Staff and Hospital policies and procedures;
 - (2) Requirements for alternate coverage and for consultation;
 - (3) Sound principles of clinical practice; and
 - (4) Regulations designed to promote patient safety.
- (d) To assure that the performance of a new appointee to the department and other members granted new clinical privileges are systematically evaluated by the department in accordance with the proctoring procedure established.
- (e) Coordinate the patient care provided by the clinical department's members with nursing and ancillary patient care services and with administrative support services.
- (f) Meet regularly as a department or as a quality committee of the department to review and analyze on a peer review basis the clinical work of the clinical department. When the quality review is delegated to a committee of the department, the full department shall meet as often as necessary to review the work of the quality committee, to transact such other business as may need attention and to comply with the standards of the Joint Commission on Accreditation of Healthcare Organizations.

- (g) Be responsible for the review of selected medical records of both inpatients and outpatients, the goal of which review shall be to accomplish timely completion of medical records, clinical pertinence, and overall adequacy.
- (h) Establish mechanisms and procedures to assess the quality and appropriateness of medical care provided by the Medical Staff and Allied Health Care Providers in the department and shall monitor the quality and appropriateness for such care.
- (i) Establish criteria and mechanisms to evaluate the standards of patient care being provided in the Hospital with a goal to providing high quality patient care in a cost effective manner.
- (j) **Special Obligations of the Medicine Department:**
 - (1) **Blood Utilization.** Review all blood transfusions and the utilization of blood and blood products based on criteria established by the department.
 - (2) **Radiation Safety.** The Radiology Medical director shall be responsible to oversee the safe use of radiation in the diagnosis and treatment of Hospital patients, through the adoption of policies and procedures and review of cases on a systematic basis. Only personnel designated as qualified by the medical staff may use the radiology equipment and administer procedures. The qualifications, training, functions, and responsibilities of radiology personnel must be specified by the Radiology Medical Director and approved by the medical staff.
 - (3) **Nuclear Medicine.** The Director of Nuclear Medicine shall be appointed by the medical staff and shall be responsible for the provision of quality nuclear medicine studies for patients and referring physicians. The director shall be responsible for the standardization of policies and procedures, radiopharmaceuticals, doses, equipment function, radiation safety and the diagnosis and/or procedural intervention, supervision and interpretation nuclear medicine imaging performed. The director's qualifications shall be approved by the medical staff. The qualifications, training, functions, and responsibilities of nuclear medicine personnel must be specified by the Director of Nuclear Medicine and approved by the medical staff.

Section V: Department Chief

- A. **Qualifications.** Each Department Chief shall be a member of the Active Staff, and must have completed an AMA-approved residency or an AOA-approved residency in a directly applicable specialty sub/specialty field and/or be Board Certified and, must have demonstrated leadership ability, willingness to set high professional standards, and to hold colleagues accountable for meeting those standards.
- B. **Selection and Tenure.** Each Department Chief shall be elected to his/her office at an annual meeting for a two-year term by those Practitioners assigned to that clinical department. Each Department Chief shall serve until the end of his/hers term and until a successor is elected. A Department Chief may be re-elected to serve another term.

Department Chief elections should be held in off years from Medical Staff Officer elections to facilitate continuity of leadership in the Medical Staff organization.

C. Duties. Each Department Chief shall:

- (1) Be accountable for all professional and administrative activities of the department and preside at all department meetings;**
- (2) Give guidance on the overall medical and surgical policies of the Hospital, and making specific recommendations and suggestions for his/hers own department or clinical department in order to assure quality patient care;**
- (3) Maintain continuing review of the professional performance of all Practitioners with privileges in his/hers department, and report as requested to the Medical Staff, Executive Committee, or to the Credentials Committee;**
- (4) Be responsible for the quality of patient care rendered by members of his/hers department and the effective conduct of the performance, evaluation, and other quality assurance functions delegated to his/hers department;**
- (5) Be responsible for enforcement of the Medical Staff Bylaws and Rules and Regulations within his/hers department;**
- (6) Be responsible for implementation within his/hers department of actions taken by the Executive Committee;**
- (7) Be responsible for teaching, education and research within his/hers department;**
- (8) Transmit to the Executive Committee and Credentials Committee his/hers department's recommendation concerning initial appointments, staff classifications, reappointment, and the delineation of clinical privileges for the Physician assigned to his/her department;**
- (9) Participate in every phase of administration of his/hers department through cooperation with the Nursing Service and Hospital Administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;**
- (10) Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Executive Committee, the Chief Executive Officer and the Board.**
- (11) The Director of Anesthesia will be appointed by the Organized Medical Staff and will be responsible for the following: Planning, directing, and supervising all activities of the service; Establishing staffing schedules, including written on-call schedule for anesthesia coverage when the department is normally closed; monitoring of the quality and**

appropriateness of the anesthesia patient care; evidence of responsibility for anesthesia services delivered in all areas of the hospital where applicable: Operating room suite(s), both inpatient and outpatient; Obstetrical suite(s); Radiology department; Clinics; outpatient surgery areas.

Section VI: Department Vice Chief

- A. **Qualifications.** Each Vice Chief shall be a member of the Active Staff qualified by training, experience, and demonstrated ability for the position.
- B. **Selection and Tenure.** Each Vice Chief shall be elected to his/hers office at an annual meeting for a two-year term by those Practitioners assigned to that clinical department. Department Vice Chief elections should be held in off years from Medical Staff Officer elections to facilitate continuity of leadership in the Medical Staff organization.
- C. **Duties.** Each Vice Chief shall perform the duties of the Department Chief in his/her absence and other duties as delegated by the Department Chief.

ARTICLE XI: OFFICERS/COMMITTEE CHAIRPERSONS

Section I: Officers of the Medical Staff

The officers of the Medical Staff shall be:

- a. Chief of Staff
- b. Vice Chief of Staff
- c. Secretary – Treasurer

Section II: Qualifications of Officers

Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section III: Election of Officers

Officers shall be elected at the annual meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote. Election shall be by majority vote of those present and voting. Proxies shall not be accepted. In the event that no candidate receives a majority of the votes cast and where there are multiple candidates, that candidate, receiving the least number of votes will be eliminated and a repeat vote taken until a candidate has received a majority of the votes cast.

Nominations for the officers of the Medical Staff may occur by either of the following methods. The Chief of Staff may appoint a Nominating Committee consisting of five members of the Active Medical Staff, which shall meet prior to the annual meeting of the Medical Staff and submit to the Chief of Staff one or more qualified nominees for each office. Nomination may also me made from the floor at the time of the annual meeting of the Medical Staff. Such nominees must be present at the meeting, meet all qualifications and express willingness to serve if elected.

Section IV: Term of Office of Officers and Chairpersons

- A. **Chief of Staff:** The Chief of Staff shall serve a two (2) year term from their election date.
- B. **Vice Chief of Staff:** The Vice Chief of Staff shall serve a two (2) year term from their election date and shall be designated Chief of Staff elect. In the event the Chief of Staff cannot serve, the vice Chief of Staff will become Chief of Staff. A successor will be elected to serve the remainder of the term of Vice Chief of Staff.
- C. **Secretary/Treasurer:** The Secretary/Treasurer shall serve a two (2) year term from their election date.
- D. **Chairperson, Quality Assessment and Utilization Review Committee:** The Chairperson of the Quality Assessment and Utilization Review Committee shall serve a two (2) year term from their appointment date.
- E. **Vice Chairperson, Quality Assessment and Utilization Review Committee:** The Vice Chairperson of the Quality Assessment and Utilization Review Committee shall serve a two (2) year term and shall be designated as Chairperson elect. In the event the Chairperson is not available or cannot continue to serve as chairperson, the Vice Chairperson shall become the Chairperson. A successor shall be appointed by the Chief of Staff to serve the remainder of the term of Vice Chairperson.
- F. **Chairperson, Credentials Committee:** The Chairperson of the Credentials Committee shall serve a two (2) year term.
- G. All officers/chairpersons shall take office/chairpersonship of the first day of the Medical Staff year, which begins January 1st.

Section V: Vacancies in Office and Removal from Office

- A. Vacancies in office during the Medical Staff year, except for the Chief of Staff, shall be filled by the Executive Committee of the Medical Staff. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve out the remaining term.
- B. Any Medical Staff officer may be removed from office by a vote of 2/3rds of the Active Staff members present at a regularly scheduled meeting of the Medical Staff when such item has been placed on the agenda by request of any member of the Active Staff prior to the regular meeting of the Medical Staff.

Section VI: Duties of Officers

- A. **Chief of Staff:** The Chief of Staff shall serve as the chief administrative officer of the Medical Staff to:
 - 1. Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Hospital;
 - 2. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
 - 3. Serve as Chairman of the Medical Staff Executive Committee;

4. Serve as ex officio officer of all other Medical Staff committees, without vote;
 5. Be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for the implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;
 6. Appoint committee members and the chairpersons thereof to all standing, special and multi-disciplinary Medical Staff committees, except the Executive Committee;
 7. Represent the view, policies, needs and grievances of the Medical Staff to the Governing Body and to the Chief Executive Officer;
 8. Receive and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
 9. Be responsible for the educational activities of the Medical Staff; and
 10. Be the spokesman for the Medical Staff in its external professional and public relations.
- B. **Vice Chief of Staff:** In the absence of the Chief of Staff, he or she shall assume all duties and have the authority of the Chief of Staff. He or she shall be a member of the Executive Committee of the Medical Staff and of the Joint Liaison Committee. He or she shall automatically succeed the Chief of Staff when the latter fails to serve for any reason.
- C. **Secretary-Treasurer:** He or she shall be a member of the Executive Committee of the Medical Staff. The Secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meeting on order of the Chief of Staff, attend to all correspondence, and perform such duties as ordinarily pertain to his or her office..

ARTICLE XII: COMMITTEES

All records of committee deliberations, as well as reports made to the Executive Committee, shall be reported as proceedings of a Peer Review Committee within the meaning of state and federal laws relating to peer review activities, and shall be confidential and privileged communications. Medical Staff committee assignments shall be limited to two (2) per active Physician member, whenever possible. This does not include Medical Staff officers.

Section I: Executive Committee

- A. **Composition:** The Executive Committee shall be a standing committee and shall consist of the Medical Staff officers, the Chief Executive Officer of the Hospital (ex officio without vote), the immediate past Chief of Staff, the Department Chiefs, the Chairman of the Credentials Committee, and the Chairman of the Quality Assessment and Utilization Review Committee. The Chief of Staff will be Chairman of the Executive Committee.

B. Meetings: Refer to ARTICLE XVI: MEDICAL STAFF MEETINGS

C. Functions: The functions of the Executive Committee shall be:

- 1. To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;**
- 2. To coordinate the activities and general policies of the Medical Staff;**
- 3. To receive and act upon committee reports as presented by the chairmen of the committees, services and other assigned activity groups;**
- 4. To implement policies of the Medical Staff;**
- 5. To provide liaison between Medical Staff and Hospital Chief Executive Officer and the Governing Body;**
- 6. To recommend action to the Hospital Chief Executive Officer on matters of medical administrative nature;**
- 7. To make recommendations on Hospital management matters to the Governing Body regarding the medical care rendered to patients in the Hospital;**
- 8. To fulfill the Medical Staff's accountability to advise the Governing Body regarding the medical care rendered to patients in the Hospital;**
- 9. To ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;**
- 10. To provide for the preparation of all meeting programs, either directly or through a delegate;**
- 11. To review the credentials of all applicants to make recommendations for staff membership and Allied Health Care Provider appointment and delineation of clinical privileges;**
- 12. To review periodically all information available regarding the performance and clinical competence of staff members and other Practitioners with clinical privileges, and as a result of such reviews, make recommendations for reappointments and renewal or changes in clinical privileges;**
- 13. To take all reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all members of the Medical Staff and other Practitioners, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;**
- 14. To make recommendations for changes in Medical Staff structure to the Governing Body;**

15. To make recommendations regarding the mechanisms designed to review credentials and delineated clinical privileges;
 16. To organize Medical Staff's role in the organization wide performance improvement activities and establish mechanism to conduct, evaluate and revise such activities;
 17. To develop a mechanism by which Medical Staff membership may be terminated;
 18. To create a mechanism designed for use in fair hearing procedures;
- D. Establish policies regarding Medical Staff membership dues, and related matters.

Section II: Quality Assessment and Utilization Review Committee

- A. **Composition:** The members of this committee shall consist of members of the Active Medical Staff appointed by the Chief of Staff. One of the Active Medical Staff members, other than the chairman, shall be a pathologist. The chairman shall be appointed by the Chief of Staff. The committee members also shall include representatives of Hospital administration named by the Chief Executive Officer, such as Nursing, Quality Improvement, and Risk Management.
- B. **Meetings:** The committee shall meet on call of the chairman, as often as necessary, but not less than six times per year; shall keep minutes of its meeting; shall report on its meetings to the Executive Committee.
- C. **Functions:** The committee shall:
1. Develop the Medical Staff's portion of the Hospital Quality Assurance Program;
 2. Identify, evaluate and where appropriate, make recommendations concerning the issues affecting the quality of care provided and the appropriate utilization of resources;
 3. Assume responsibility for assuring systematic and ongoing reviews of patient care by each department and/or clinical service;
 4. Ensure that the quality assurance requirements of external, regulatory accrediting bodies are met;
 5. Determine from the results of reviews the need for educational activities or other appropriate action when necessary;
 6. Develop the reporting mechanisms necessary for assuring appropriate follow through;
 7. Review pertinent results from Hospital clinical department Quality Assurance programs;

8. Review the results and subsequent actions (follow through) taken to the related quality assurance reviews in each Medical Staff department;
9. Refer all problems and/or problem cases identified to the appropriate clinical or clinical service department for review and appropriate action;
10. Utilization Management issues will be reported at least quarterly or more frequently as deemed appropriate to this committee. The committee may appoint physician/dentist outside of the committee to perform concurrent or retrospective chart reviews for utilization management. Peer review privilege applies in accordance with Indiana Peer Review Statute I.C. 34-4-12.6.1.
11. Review and assess clinical effectiveness of clinical pathways instituted by the Medical Staff;
12. Function as a continuing medical education committee by:
 - (a) Identifying and analyzing the medical education needs of the Medical Staff;
 - (b) Formulating educational objectives for each CME presentation; and
 - (c) Recommending to the Executive Committee policies and procedures for documenting each Medical Staff member's participation in continuing medical education (see also Article XIX of these Bylaws)

Section III: Joint Liaison Committee

- A. **Composition:** The members of this committee shall consist of the 5 members of the Governing Body, 4 Active Medical Staff members—Chief of Staff, Vice Chief of Staff, Secretary, and one other Physician appointed by the Chief of Staff, the Chief Executive Officer, and The Director of Nursing. The chairman shall be the President or Chairman of the Governing Body.
- B. **Meetings:** The committee shall meet on call of the chairman and shall keep minutes of its meetings.
- C. **Functions:** When the Governing Body takes an action which when final would be at variance with recommendations of the Medical Staff, the Joint Liaison Committee shall meet to discuss the matter in controversy. However, the Governing Body will not be bound by the recommendations.

Section IV: Intensive Care Unit Committee

- A. **Composition:** The members of this committee shall consist of 3 members of the Active Medical Staff who shall be appointed by the Chief of Staff annually. The chairman shall be 1 of the 3 Physicians on the committee and shall be the Physician advisor to the Hospital

ICU services. Nursing shall be represented by 2 nurses as designated by the Director of Nursing.

- B. **Meetings:** The committee shall meet on call of the chairman, at least quarterly; shall keep minutes of its meetings; shall report at least quarterly to the Executive Committee.
- C. **Functions:**
 - 1. The committee shall review and evaluate the quality, safety, and appropriateness of patient care in ICU.
 - 2. The committee shall be responsible for reviewing, formulating, and recommending changes in policies and procedures regarding the continuing operation of the unit.
 - 3. The committee shall recommend pertinent educational programs and/or other actions toward the goal of improvement of patient care.

Section V: Credentials Committee

- A. **Composition:** There shall be an appropriate number of Active Medical Staff members representing major clinical Services to serve as the Credentials Committee for the Medical Staff.
- B. **Meetings:** The committee shall meet on call of the chairman as often as necessary, but not less than six times per year; shall keep minutes of its meetings; shall report at the next Executive Committee meeting following any committee meeting.
- C. **Functions:**
 - 1. The committee shall review the credentials and qualifications, as well as recommendations of Department Chiefs, regarding all new applicants and reapplicants for Medical Staff membership and Allied Health Care Providers appointment.
 - 2. The committee shall review the competence and privileges requested from new applicants and reapplicants.
 - 3. The committee shall make recommendations for membership on the Medical Staff, appointment of Allied Health Care Providers, and for the granting of privileges to the Executive Committee.
 - 4. The committee shall serve as a review committee on the suspension or termination of any Physician-employed medical assistant's privileges as provided in these Bylaws.
 - 5. The committee shall serve as an Impaired Physician Committee to counsel and monitor the progress of any Physician who voluntarily places himself or herself under the supervision of the committee.

6. Every three (3) years, these Bylaws as a whole shall be reviewed and revised as necessary by the Credentials Committee. They shall be presented to the Executive Committee for adoption at the Medical Staff annual meeting in November and be presented at the December meeting of the Governing Body for their approval.

Each and every Practitioner or applicant for privileges at the Hospital may have the right to examine any and all materials contained in his or her credentials or personal file, but shall not have the right to examine any information in any other Practitioner's credentials or personal file.

Section VI: Infection Control Committee

- A. **Composition:** There shall be an Infection Control Committee, the majority of whom shall be members of the Active Medical Staff. Membership shall be multidisciplinary and may include both adult and pediatric Physician representatives from departments or subsections of Medicine, Surgery, Pediatrics and Pathology and Laboratory Medicine. In addition, the Infection Control Nurse/Manager will be a voting member. Nursing Services, Hospital Administration, Environmental Services and Hospital Facilities Department will be represented. Representation from Central Services, Laundry, Dietary, Pharmacy and Operating Rooms will be available on a consultative basis.
- B. **Meetings:** The committee shall meet on call of the chairman, at least quarterly; shall keep minutes of its meetings; shall report monthly to the Medical Staff/Executive Committee and to the Chief Executive Officer.
- C. **Functions:**
 1. The committee shall adopt a system for surveillance, reporting, evaluating, and maintaining records of infections.
 2. The committee shall review and evaluate techniques in the Hospital infection risk control and establish procedures for preventive surveillance.
 3. The committee shall regularly review employee health programs and other programs related to infection prevention and control.
 4. The committee shall have the authority to institute appropriate control measures when it appears that there may be an emergency condition or danger to patients or others.

Section VII: Pharmacy and Therapeutics Committee

- A. **Composition:** There shall be a Pharmacy and Therapeutics Committee, the majority of whom shall be members of the Active Medical Staff. Membership shall include both adult and pediatric representatives. Membership shall also include the Pharmacy Manager, a Pharmacist with content expertise required and representatives from Hospital Administration, Nursing Services, Performance Improvement and other disciplines deemed appropriate by Committee with only the Pharmacy Manager or designee as voting member.

B. **Meetings:** The committee shall meet on call of the chairman; at least every other month; shall keep minutes of its meeting; shall report to the Quality Assessment and Utilization Review Committee.

C. **Functions:**

1. The committee shall develop and conduct surveillance of all drug policies and practices within the Hospital in order to assure optimum clinical results with a minimum of potential hazards.
2. The committee shall develop and maintain a drug formulary.
3. The committee shall evaluate drug usage to ensure the appropriate, safe, and effective use of drugs.

Section VIII: Special Committees

Special committees may be appointed from time to time as may be required to carry out the duties of the Medical Staff. The members of these committees shall be appointed by the Chief of Staff.

Such committees shall confine their work to the special area or problem presented, and shall report to the Executive Committee. They shall have no power of action unless such is specifically granted by the Chief of Staff, and when these committees have served their purposes, they shall be dissolved.

Section IX: Cancer Committee

A. **Composition:**

The cancer committee will be multidisciplinary and must have at least one Physician member from each of the required specialties: radiology, pathology, general surgery, medical oncology and radiation oncology.

The committee will also require the following non-Physician members: cancer program administrator, oncology nursing, social services, rehabilitation cancer registry and quality improvement.

The following committee members are not required but preferred. These members will be designated associates and includes: nutrition, pastoral care, American Cancer Society representative and cancer care guide(s).

The cancer committee chair is a Physician and may also fulfill the role of a required specialist.

The Cancer Liaison Physician must be a member of the cancer committee and fulfill the role of a required Physician specialist.

B. **Meetings:** This committee reports to the medical section and/or the medical executive committee.

The cancer committee cannot be dissolved except by action of the medical section or medical executive committee.

Meetings will be held at least quarterly.

Only the required members of the committee will be accountable for the established attendance requirement. All others are encouraged to attend.

- C. **Responsibilities:** The cancer committee is responsible for planning and accessing all cancer-related activities.

The cancer committee will function as a policy advisory and administrative body.

The committee will appoint one coordinator for each area of cancer committee activity.

The Cancer Liaison will work closely with the American Cancer Society representative and the community outreach coordinator.

The cancer committee will develop and evaluate annual goals/objectives for each area of cancer committee activity.

The cancer committee establishes format, frequency and attendance requirements for cancer conferences and cancer committee meetings.

Ensure that at least 75% of the cases discussed at the cancer conference are presented prospectively and at least 10% of the analytic cases are reviewed.

The cancer committee will monitor the discussion surrounding cases presented prospectively at cancer conference and ensure that these discussions include the AJCC or other appropriate stage.

Implement at least 2 improvements that directly affect patient care.

Establish subcommittee or workgroup when appropriate.

Offer 2 cancer-related educational activities each year.

Review the percentage of cases accrued to clinical trials annually and implement a mechanism to educate patients about cancer related trials.

Monitor/evaluate community outreach activities annually.

Review 10 percent of the analytical cases to ensure that at least 90 percent of the pathology reports include the scientifically validated data elements outlined in the CAP protocols.

Complete at least one site-specific study that includes outcome data and distribute the results to the Medical Staff.

Establishes a plan to evaluate the quality of registry data and activity on an annual basis.

- D. The Cancer Committee cannot be dissolved except by action of the Medical Staff.

ARTICLE XIII: MEDICAL STAFF MEETINGS

Section I: Regular Meetings

- A. Regular meetings of the Medical Staff shall be held at least annually at time and place to be provided for in the Rules and Regulations for the government of the Medical Staff. The Chief of Staff may establish more frequent regular meetings depending on the volume of business and issues requiring the participation of the Medical Staff membership as a whole. The annual meeting of the Medical Staff shall be at the January meeting or as soon as practicable thereafter. The order of business at the annual meeting of the Medical Staff shall be determined by the Medical Staff President and the Medical Staff Council. The agenda shall include, insofar as feasible:
- a. reading and acceptance of the minutes of the last annual and all special Medical Staff meetings held since the last annual meeting;
 - b. reports from the Medical Staff Chief of Staff, departments and committees and the Chief Executive Officer of the Hospital, including actions taken during the preceding year and other matters of interest and importance to the members;
 - c. election of officers;
 - d. reports by responsible officers, committees and departments on the overall results of patient care evaluation and other performance assessment and improvement activities of the Medical Staff and on the fulfillment of other required Medical Staff functions;
 - e. old business; and
 - f. new business.

Section II: Special Meetings

- A. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within ten (10) days after the receipt by him of a written request for such a meeting, signed by not less than one-fourth (1/4) of the Active Medical Staff and stating the purpose of such meeting. The Chief of Staff shall designate the time and place of any special meeting.
- B. Written or printed notice stating the place, date, hour, and purpose of any special meeting of the Medical Staff shall be delivered either personally or by mail to each member of the Active Medical Staff not less than seven (7) days prior to the date of the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited postage prepaid in the United States mail, addressed to each staff member at his address as it appears on the records of the Hospital. Notice may also be sent to members of other Medical Staff groups who have so requested. The attendance of a member of the Medical Staff at any meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section III: Quorum

The presence of at least twenty-five (25) members of the Active Medical Staff at any regular or special meeting shall constitute a quorum for purposes of amendments to these Bylaws, Rules and Regulations, as well as all other actions.

ARTICLE XIV: COMMITTEE MEETINGS

Section I: Regular Meetings

Committees may by resolution, provide the time for holding regular meetings without notice other than such resolution.

Section II: Special Meetings

Special meetings of any committee may be called by the chairman, the Chief of Staff, or by one-third (1/3) of the membership but not less than two (2) members.

Section III: Notice of Meetings

Written or oral notice stating the place, date, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee not less than five (5) days before time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the Hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of such meeting.

Section IV: Quorum

Fifty percent (50%) of the Active Medical Staff members of the committee but not less than two (2) members shall constitute a quorum at any meeting.

Section V: Manner of Action

The action of a majority of members present at a meeting at which a quorum is present shall be the action of a committee. Action may be taken without a meeting by unanimous consent in writing (setting forth actions so taken) signed by each member entitled to vote.

Section VI: Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. Each committee shall maintain a permanent file of the minutes of each meeting.

ARTICLE XV: IMMUNITY FROM LIABILITY

1. The following shall be express conditions to any Practitioner's application for, or exercise of, clinical privilege at this Hospital. Since the Governing Body has the overall responsibility for the conduct of the Hospital in a manner consonant with the Hospital's objective of making available appropriate patient care, and since the organized Medical Staff has the overall responsibility as the agents of the Governing Body to conduct peer review regarding the quality of all medical care provided to patients and for the ethical conduct and professional practices of its members, as well as for accounting therefore to the Governing Body, it is of the greatest importance that the most careful consideration be given to appointments and reappointments in these matters, completed candor is required. Also, the Hospital, through its Medical Staff and management, owes a duty to other hospitals and health care institutions, to respond candidly to requests for reference and evaluations of Practitioners and of other health care personnel practicing, employed or training at the Hospital.
2. That any act, communication, report, recommendation, or disclosure, with respect to any such Practitioner, performed or made in good faith and without malice and at the

request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

3. That such privileges shall extend to members of the Hospital's Medical Staff and its Governing Body, its other Practitioners, its administrator and his representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same.

For the purpose of this Article, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Body or of the Medical Staff.

4. That there shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.
5. That such immunity shall apply to all acts, communications, reports, recommendation, or disclosure performed or made in connection with this or any other health care institution's activities related, but not limited to:
 - a. Applications for appointment or clinical privileges;
 - b. Periodic reappraisals for reappointment or clinical privileges;
 - c. Corrective action, including summary suspension;
 - d. Hearings and appellate reviews;
 - e. Medical care evaluations;
 - f. Utilization reviews;
 - g. Other Hospital or committee activities related to optimal patient care and inter-professional conduct.
6. That the acts, communications, report, recommendations, and disclosures referred to in this Article, may relate to a Practitioner's professional qualifications, clinical competency, character, mental and emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.
7. That in furtherance of the foregoing, each Practitioner shall upon request of the Hospital execute a release in accordance with tenor and import of the Article in favor of the individuals and organizations specified herein subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the law of this state.
8. That the consents, authorizations, release, rights, privileges, and immunities provided by these Bylaws for the protection of this Hospital's Practitioners, other appropriate Hospital officials and personnel, and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article .

ARTICLE XVI: CONTINUING MEDICAL EDUCATION

In the interest of maintaining a high caliber of medical practice, all members of the Medical Staff are required to engage in a program of continuing medical education. There shall be a minimum annual requirement of twenty-five (25) hours of AMA Category I continuing medical education.

ARTICLE XVII: RULES AND REGULATIONS

All rules and regulations governing the Medical Staff shall be initiated by the Medical Staff and approved by the Governing Body before becoming effective. A proposal for an amendment to the Rules and Regulations may be submitted in writing to the Medical Executive Committee (MEC) by the Board of Managers, the CEO of IU Health West Hospital or by any member of the Medical Staff. The MEC may also modify the proposal and then vote to accept or reject the proposal in its original form or as modified. If the proposal is accepted, it shall be e-mailed, mailed or faxed to each member of the Medical Staff. The proposal shall then be voted upon by the Medical Staff, such vote to be accomplished as directed by the MEC (e.g. at a meeting or by mail, e-mail, or fax). The proposal shall be considered approved if it receives the affirmative vote of a majority of the received votes. The amendment shall become effective upon approval of the Board of Managers. Revised texts of significant changes to the Rules and Regulations shall be provided to all Medical Staff members and Allied Health Care Providers

ARTICLE XVIII: AMENDMENTS

A proposal for an amendment to the Bylaws may be submitted in writing to the Medical Executive Committee (MEC) by the Board of Managers, the CEO of IU Health West Hospital or by any member of the Medical Staff. The MEC may also modify the proposal and then vote to accept or reject the proposal in its original form or as modified. If the proposal is accepted, it shall be e-mailed, mailed or faxed to each member of the Medical Staff. The proposal shall then be voted upon by the Medical Staff, such vote to be accomplished as directed by the MEC (e.g. at a meeting or by mail, e-mail, or fax). The proposal shall be considered approved if it receives the affirmative vote of two-thirds of the received votes. The amendment shall become effective upon approval of the Board of Managers. Revised texts of significant changes to the Medical Staff Bylaws shall be provided to all Medical Staff Members and Allied Health Care Providers.

ARTICLE XIX: ADOPTION

These Medical Staff Bylaws were adopted at the regular meeting of the Governing Body of the Hospital on the ___ day of _____, ____ to be immediately effective.

ARTICLE XX: REVIEW AND READOPTION

These Medical Staff Bylaws will be reviewed and readopted every three (3) years.

Revised:	1/24/2006
Revised approved by MEC :	6/30/08
Revised approved by Board of Managers:	11/10/2008
Revised:	1/30/2010
Revised approved by MEC:	3/29/2010
Revised approved by MEC:	12/17/2011
Revised approved by Board of Managers:	3/14/2011