

**MEDICAL STAFF BYLAWS**  
**MEMORIAL HOSPITAL OF SOUTH BEND, INC**  
**SOUTH BEND, INDIANA**

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# MEDICAL STAFF BYLAWS / MEMORIAL HOSPITAL OF SOUTH BEND, INC

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# MEDICAL STAFF BYLAWS / MEMORIAL HOSPITAL OF SOUTH BEND, INC

## ARTICLE ONE: PURPOSES AND AUTHORITY OF THE MEDICAL STAFF

- 1.1 **ESTABLISHMENT OF THE MEDICAL STAFF.** There shall be established within the Hospital an organized, self-governing Medical Staff which shall consist of all Physicians, Dentists, and Podiatrists who have been granted Membership and/or the right to exercise Clinical Privileges within the Hospital. No Physician, Dentist, or Podiatrist shall admit or provide medical or healthcare related services to any patient in the Hospital unless he or she has been granted Privileges. In order to ensure the provision of quality patient care, treatment, and services, the Hospital Board shall, in the exercise of its discretion, delegate to the Medical Staff the responsibility for providing oversight of the care, treatment, and services provided by Practitioners with Privileges. The Medical Staff shall conduct a continuing review and appraisal of the quality of professional care rendered in the Hospital and shall report such activities and their results to the Board of Trustees.
- 1.2 **ULTIMATE AUTHORITY OF THE BOARD OF TRUSTEES.** The Board of Trustees of the Hospital specifically reserves the authority to take any direct action that is appropriate with respect to any individual appointed to the Medical Staff or granted Clinical Privileges or the right to practice in the Hospital. Subject to the authority and approval of the Board, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and under the corporate bylaws of Memorial Hospital of South Bend, Inc. and in compliance with law and regulation. The Medical Staff and each of its Members and Privilege holders shall comply with these Bylaws and the Related Manuals and the Medical Staff Rules and Regulations and Policies. The Organized Medical Staff, through its leadership structure, shall take such action or recommend such action to the Board as is necessary to enforce these Bylaws and the Related Manuals and to enforce the Medical Staff Rules and Regulations and Policies.
- 1.3 **PROFESSIONAL PEER REVIEW BODIES.** The Hospital Board and the Medical Staff constitute themselves as Professional Review Bodies as defined by the Health Care Quality Improvement Act of 1986, as amended (42.U.S.C. § 11101 et seq.), and the Indiana Peer Review Act (I.C. 34-30-15 et seq.); and the Hospital and the Medical Staff claim all privileges and immunities afforded under the Health Care Quality Improvement Act of 1986, as amended, and the Indiana Peer Review Act.

## ARTICLE TWO: MEMBERSHIP AND PRIVILEGES

- 2.1 **GENERAL QUALIFICATIONS**  
No Practitioner shall be entitled to Membership on the Medical Staff or to Clinical Privileges merely by virtue of licensure, certification by any specialty board, membership in any professional organization or on any medical school faculty, past Staff Membership and/or Privileges at this Hospital, or past or present staff membership and/or privileges at any other healthcare facility.
- 2.1-1 **GENERAL QUALIFICATIONS FOR MEMBERSHIP AND PRIVILEGES**  
The following qualifications must be continuously met by all Members of the Medical Staff, by all applicants for Membership with the Medical Staff, and by all Practitioners who request or hold Privileges.
- A. **Licensure.** Have a currently valid and unrestricted license to practice in the State of Indiana
  - B. **Professional Degree.** Have a Doctor of Medicine, Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Osteopathy, or Doctor of Podiatric Medicine Degree
  - C. **Board Certification.** An applicant must be board certified and/or subspecialty certified by a member board of the American Board of Medical Specialties (ABMS), a member board of the American Osteopathic Association Bureau of Osteopathic Specialists (AOABS), the American Board of Oral and Maxillofacial Surgery, the American Board of Foot and Ankle Surgery, the American Board of Podiatric Medicine, or the Royal College of Physicians and Surgeons of Canada; or an applicant must have within the last five (5) years completed a graduate training program which qualifies the applicant to seek certification by one of these certifying organizations. Those who have recently completed a residency or fellowship program must become certified before five (5) years have transpired since the date of

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completion of their latest residency or fellowship training in order to qualify to retain Membership and/or Privileges. The MEC may in its sole discretion and after individual application by a Member or Privilege Holder, extend the five (5) years limit up to seven and one-half (7.5) years. (This board certification requirement does not apply to dentists and is applicable only to those individuals who receive initial Staff appointment or initial grant of Privileges on or after 7/1/2008. Those individuals who applied for and received initial Staff appointment or initial grant of Privileges prior to 7/1/2008, and who have continuously maintained that appointment and/or those Privileges, will be considered grandfathered under this clause.)

D. **Maintenance of Board Certification.** All Members and all Privilege holders who are required by these Bylaws to attain board certification and/or subspecialty certification by a member board of the American Board of Medical Specialties (ABMS), a member board of the American Osteopathic Association Bureau of Osteopathic Specialists (AOABS), the American Board of Oral and Maxillofacial Surgery, the American Board of Foot and Ankle Surgery, the American Board of Podiatric Medicine, or the Royal College of Physicians and Surgeons of Canada, must also continuously maintain at least one board certification and/or subspecialty certification. The “continuous” aspect of this maintenance requirement may be temporarily waived for periods up to thirty (30) months by individual application to the MEC which may act in its sole discretion. (This board certification maintenance requirement does not apply to dentists and is applicable only to those individuals who receive initial Staff appointment or initial grant of Privileges on or after 7/1/2011. Those individuals who applied for and received initial Staff appointment or initial grant of Privileges prior to 7/1/2011, and who have continuously maintained that appointment and/or those Privileges, will be considered grandfathered under this clause. The “continuously maintained” aspect of appointment and Privileges shall not be deemed interrupted by Automatic or Summary Suspension or by Leave of Absence.)

E. **Character/Reputation.** Applicants applying or reapplying for Medical Staff Membership and/or Clinical Privileges must demonstrate a professional reputation consistent with the Hospital’s Core Values. There shall be no adverse professional licensure actions, felony convictions or felony guilty pleas within the three (3) years immediately preceding receipt of an application. Applicants must also have no current or pending sanction or exclusion from governmental health care programs. Applicants who are deemed to have engaged in behavior inconsistent with the Medical Staff Code of Professional Behavior are presumed to not be appropriate for Staff Membership and/or Privileges. (Collectively, “Adverse Reputation”)

Such applicants must provide compelling evidence satisfactory to the Credentials Committee that their Adverse Reputation will not place an undue burden on the Medical Staff, individual physicians, the Hospital staff, or Hospital patients before they will be entitled to receive an application or reapplication or to have their application or reapplication processed. Applicants who do not, in the opinion of the Credentials Committee, satisfactorily resolve issues related to their Adverse Reputation will be administratively declined. Such declination will not be deemed an Adverse Action, will not trigger Fair Hearing rights and will not require a report to be filed with the National Practitioner Data Bank unless otherwise required by law.

F. **Verbal and Written Communication Skills.** Each Member of the Medical Staff and each Privilege holder must have the ability to read and understand the English language, to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

G. **Attitude.** Each applicant, Staff Member, and Privilege holder must have and must continuously demonstrate a willingness and capability, based on current attitude and evidence of performance:

1. To work with and relate to other Staff Members and Privilege holders, members of

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other health disciplines; Hospital management, visitors, and employees; and the community in general, in a cooperative and professional manner;

2. To adhere to the Code of Conduct for Medical Staff Members and Allied Health Professionals as outlined in the Medical Staff Code of Professional Behavior;
  3. To adhere to generally recognized standards of medical and professional ethics, including, without limitation, the Standards of Professional Conduct as promulgated by the Indiana Medical Licensing Board; and
  4. To discharge the Basic Obligations of Members and Privilege Holders as established in these Bylaws and to participate equitably in the discharge of the Staff obligations specific to any Staff Membership category to which they may be assigned.
- H. **Conflict of Interest.** A conflict of interest arises when there is a divergence between a Medical Staff Member's private interests and his/her professional obligations pursuant to the Medical Staff Bylaws, Rules and Regulations, or other Medical Staff governance documents. No Member shall participate in a Medical Staff Committee deliberation or vote, nor take any action in his or her capacity as a Medical Staff Officer, Chairperson, Chief, or in any other Medical Staff leadership capacity, if the Member has (a) an actual conflict of interest or (b) a potential conflict of interest sufficient to render the Member incapable of making a determination that is reasonably based upon the pertinent circumstances and that is in the best interests of patient safety, the Medical Staff, and the Hospital.
1. An actual conflict of interest exists if a Member: (a) is the Practitioner under review (or is a first degree relative or spouse of such Practitioner), (b) authored the complaint giving rise to the review, or (c) has an admitted and material bias in the matter. All actual conflicts of interest shall be disclosed to the applicable Committee, Committee Chairperson, Medical Staff President, and/or VPMA.
  2. Potential conflicts of interest may be personal or financial in nature. The following are representative, but not all inclusive, of circumstances that may give rise, upon further review, to a potential conflict of interest sufficient to preclude a Member's participation pursuant to this section:
    - A Member was directly involved in rendering clinical care to the patient subject of review, even though the Member is not the Practitioner subject of the review;
    - A Member previously voted on the same issue/matter in connection with another Medical Staff Committee;
    - A Member is a business partner of the Practitioner subject of the review, regularly receives referrals from the Practitioner under review, or otherwise has a direct financial interest in the outcome of the review;
    - A Member is in direct economic competition with the Practitioner under review such that adverse action taken against the Practitioner (if adverse action is a potential result of the review) will result in direct financial gain to the Member;
    - A Member is involved in a real or perceived personal conflict with the Practitioner under review.
  3. Potential conflicts of interest shall be disclosed or reported to the applicable Committee, Committee Chairperson, Medical Staff President, and/or VPMA. Any person may raise the possibility of a potential conflict of interest. When a potential conflict of interest is raised, it is the responsibility of the applicable Committee (with whom the Member is participating) to consider the matter and determine whether a

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potential conflict of interest exists sufficient to render the Member incapable of making a determination that is reasonably based upon the pertinent circumstances and that is in the best interests of patient safety, the Medical Staff, and the Hospital. If a potential conflict of interest is raised with respect to a Medical Staff Officer, Chairperson, Chief, or other Medical Staff leader in connection with a function unrelated to a particular Committee, the concern should be communicated to and addressed by the MEC.

4. Nothing in this Section, without more, is intended to preclude a Member from participating in a review or other matter solely because the Member practices within the same medical specialty as the Practitioner under review or subject of the matter. Similarly, nothing in this Section, without more, is intended to preclude a Member from participating in a review or other matter solely because the Member is employed by the Hospital or is employed by an affiliated Beacon entity.
5. Notwithstanding the foregoing, as set forth in the Corrective Action and Fair Hearing Manual, no Member that is in direct economic competition with an affected Practitioner may serve on a Hearing Committee, even if such circumstance would not require removal pursuant to this Section.
6. Nothing herein precludes a Member from recusing himself/herself from participating in a deliberation or vote even though a potential conflict of interest sufficient to strictly require removal pursuant to this Section has not been identified.

## 2.1-2

### **GENERAL QUALIFICATIONS FOR CLINICAL PRIVILEGES**

The following additional qualifications must be continuously met by Practitioners with Privileges:

- A. **Clinical Performance.** Each Practitioner must be able to demonstrate, to the satisfaction of the MEC; sufficient professional education, relevant training or experience, and current competence in their respective fields. Practitioners must maintain a continuing ability to provide patient care services at an acceptable level of quality and efficiency consistent with available resources and the current state of the healing arts. In addition, Practitioners are expected to maintain competence in the following general areas:
  - Ability to provide patient care that is appropriate and consistent with generally accepted standards.
  - Demonstrate knowledge of established and evolving biomedical, clinical, and social sciences; and the application of this knowledge.
  - Ability to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
  - Demonstrate interpersonal and communication skills that enable professional relationships to be established and maintained.
  - Demonstrate behaviors that reflect a commitment to continuous professional development and ethical practice.
  - Demonstrate a responsible attitude, and an understanding and sensitivity to diversity
  - Demonstrate an understanding of both the context and systems in which health care is provided.
- B. **Continuous Patient Care.** Practitioners must assure adequate and timely professional care for their patients by being physically available in the Hospital within a reasonable period of time or by designating a qualified alternate Practitioner with whom prior arrangements have been made. The alternate Practitioner must have Clinical Privileges at this Hospital appropriate for the designating Privilege holder's practice. The determination of whether a Practitioner satisfies these standards will be made by the MEC in its sole

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discretion.

- C. **Disability.** Practitioners must have under adequate control, with or without any reasonable accommodation, any physical disability, mental disability, or any difficulty in effectively communicating verbally or in writing that interferes with, or presents a substantial probability of interfering with, the exercise of the specific Privileges requested by or granted to the Practitioner; or that interferes with, or presents a substantial probability of interfering with, the fulfillment of the Basic Obligations Of Members And Practitioners.
- D. **Professional Liability Insurance.** Each Privilege Holder must possess and maintain status as a qualified health care provider within the meaning of the Indiana Medical Malpractice Act (I.C. 34-18 et seq.) and provide evidence of professional liability insurance of a type and in the amount that is established by the Board after consulting with the MEC.

## 2.1-3 **NONDISCRIMINATION**

Medical Staff Membership or particular Clinical Privileges shall not be denied on the basis of age, gender, race, creed, color, national origin, or disability. Privileges shall be granted on the basis of a Practitioner's professional ability to provide quality patient care in accordance with these Bylaws.

## 2.1-4 **ARBITRATION**

Any dispute, claim, or controversy arising from the denial or termination of Medical Staff Membership or Clinical Privileges allegedly on the basis of an individual's age, gender, race, creed, color, national origin, or disability shall be submitted to final and binding arbitration pursuant to the rules of the American Arbitration Association and the decision thereof shall be the exclusive remedy for any such dispute, claim, or controversy.

## 2.2 **BASIC OBLIGATIONS OF MEMBERS AND PRIVILEGE HOLDERS**

Each Member of the Medical Staff, regardless of assigned Staff category, and each Practitioner exercising Privileges under these Bylaws, shall:

- A. Provide medical care at the professional level of quality and efficiency recognized by the Medical Staff;
- B. Abide by the Medical Staff Bylaws and Related Manuals, and abide by all other lawful standards, policies, and Rules and Regulations of the Staff and Hospital.
- C. Be responsible for such Staff, Committee, Department, or Hospital functions as imparted by Staff category assignment, appointment, election, or otherwise; including mandatory participation in Emergency Department call and other specialty coverage programs as scheduled or as required by the MEC.
- D. Abide by generally recognized standards of medical and professional ethics and those standards of conduct established by the Medical Staff.
- E. Accept responsibility for the supervision and performance of any Allied Health Professional (AHP) employed by the Member or Privilege holder and require that such AHP abide by the requirements of these Bylaws and the AHP Rules and Regulations; and
- F. Prepare and complete in a timely fashion the medical and other required records for all patients admitted to the Hospital or in any way provided care to in the Hospital and in particular:
  - A medical history and physical examination must be completed and documented by a physician, an oral maxillofacial surgeon, podiatrist, or other qualified licensed individual in accordance with State law and Medical Staff policy.
  - A medical history and physical examination must be completed no more than 30 days before and no more than 24 hours after admission or registration, but prior to surgery or any procedure requiring anesthesia services.
  - When the medical history and physical examination are completed within 30 days prior to admission or registration, an updated examination of the patient, noting any changes in the patient's condition must be completed and documented within 24 hours after admission or registration, but prior to surgery or any procedure requiring anesthesia services.

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- The minimum required content of a history and physical examination is delineated in the Medical Staff Rules and Regulations.

## 2.3 **MEMBER RIGHTS**

Each Member of the Medical Staff and each Practitioner with Privileges has the right to:

- A. Initiate a recall election of a Medical Staff Officer by presenting a petition signed by 10% of the Active Medical Staff Members and by following the procedure as outlined in these Bylaws;
- B. Meet with the MEC on matters relevant to the responsibilities of the MEC or challenge any rule or policy established by the MEC by presenting a petition referencing the matter and signed by 10% of the Active Medical Staff Members;
- C. Call a Medical Staff meeting to discuss a matter relevant to the Medical Staff by presenting a petition signed by 10% of the Active Medical Staff Members;
- D. Call for a Department meeting by presenting a petition signed one-third of the members of that Department;
- E. A Hearing/appeal pursuant to the circumstances, conditions, and procedures described in these Bylaws and in the Medical Staff Fair Hearing Plan; and
- F. Communicate with the Board concerning any rule, regulation, or policy adopted by the MEC or the Organized Medical Staff. The method of such communication shall be established by the Board.
- G. Immunity from civil liability, to the fullest extent permitted by law, from any act, communication, report, recommendation, or disclosure, performed at the request of an authorized Member of the Medical Staff, or Hospital management; or performed in accordance with these Bylaws or the Related Manuals or policies adopted by the Hospital or the Medical Staff for the purpose of improving or maintaining the quality of patient care. Hospital shall indemnify the legal related expenses of any Medical Staff Member, that are incurred as a result of carrying out assigned administrative/Medical Staff duties which were performed in good faith, including Peer Review and credentialing activities.

## 2.4 **APPOINTMENT/REAPPOINTMENT**

**2.4-1 CREDENTIALING PROCESS:** Upon receipt of a completed application for Medical Staff Membership and/or Privileges; verification of current licensure, education, relevant training, and current competence from the primary source, whenever feasible, or from a credentials verification organization, will be obtained. When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there is documentation of attempts to contact the primary source. A complete and verified application will be reviewed and acted on by the Chief of the applicable Department, the Credentials Committee, the MEC, and Board of Trustees.

All individuals and groups reviewing, making recommendations or acting on an application for Staff Appointment and/or Clinical Privileges will do so in a timely manner and in good faith. Under normal circumstances, an application will be processed within 120 calendar days; however, this time period is deemed a guideline and does not create any right to have an application processed within such time period.

Telemedicine Privileges may be granted based on credentialing decisions at the applicant's Distant Site provided such Distant Site is a Joint Commission accredited facility.

**2.4-2 REAPPOINTMENT PROCESS:** All Medical Staff Membership reappointments and renewals of Clinical Privileges are for a period not to exceed 24 months. Under certain circumstances, the MEC, with the approval of the Board, may require more frequent appraisals for individuals with physical or mental disabilities that limit their ability to perform the specific Privileges granted or to meet the Basic Obligations of Members and Practitioners as established in these Bylaws.

**2.4-3 DETAILS:** Details of the appointment/reappointment/credentialing procedures reside in the Credentialing Procedures Manual.

## 2.5 **PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES**



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## 2.5-1 **QUALIFICATIONS**

A Practitioner who is or who will be providing specified professional services pursuant to a contract with the Hospital must meet the same Membership qualifications; must be processed for appointment, reappointment, and grants of Clinical Privileges in the same manner; and must fulfill all of the obligations of their individual Membership category in the same manner as any other applicant, Staff Member, or Privilege Holder.

## 2.5-2 **EFFECT OF CONTRACT EXPIRATION OR TERMINATION**

- A. The effect of expiration or other termination of a contract on a Practitioner's Staff Membership status and Clinical Privileges will be governed solely by the terms of the Practitioner's contract with the Hospital, if the contract addresses the issue.
- B. If the contract is silent on the matter, then contract expiration or other termination alone will have no effect on the Practitioner's Staff Membership status or Clinical Privileges.

## 2.6 **MEDICO-ADMINISTRATIVE OFFICERS**

### 2.6-1 **DEFINED**

A Medico-Administrative Officer is a Practitioner engaged by the Hospital either full or part-time in an administrative capacity; whose activities may also include clinical responsibilities such as direct patient care, teaching, or the supervision of patient care activities of other Practitioners who are under the Medico-Administrative Officer's direction.

### 2.6-2 **STAFF MEMBERSHIP, CLINICAL PRIVILEGES AND MEMBERSHIP OBLIGATIONS**

A Medico-Administrative Officer must achieve and maintain Medical Staff Membership and Clinical Privileges appropriate to (delineated or assigned) clinical responsibilities, and must discharge Staff obligations appropriate to their individual Staff category, in the same manner as any other Staff Member.

### 2.6-3 **EFFECT OF REMOVAL FROM OFFICE OR ADVERSE CHANGE IN MEMBERSHIP STATUS OR CLINICAL PRIVILEGES**

- A. The effect of removal from the Medico-Administrative office on the Officer's Staff Membership status and Clinical Privileges, and the effect of an adverse change in an Officer's Staff Membership status (less than total revocation) or Clinical Privileges on continuance in the Medico-Administrative office, will be governed solely by the terms of the contract between the Officer and the Hospital, if the contract addresses these issues. An adverse change in Membership status or Clinical Privileges not triggered by removal from a Medico-Administrative office entitles the Medico-Administrative Officer to the procedural rights contained in the Fair Hearing Plan.
- B. In the absence of a contract or where the contract is silent on the matter, removal from Medico-Administrative office alone will have no effect on Membership status or Clinical Privileges, except that the Practitioner may not thereafter exercise any Clinical Privileges for which other exclusive contractual arrangements have been made. Continuance in Medico-Administrative office following loss of Staff Membership is not permissible; however, the effect of an adverse change in Clinical Privileges on continuance in Medico-Administrative office will be determined by the Board after soliciting and considering the recommendations of relevant components and officials of the Medical Staff.
- C. Unless the contract provides otherwise, a Practitioner who demonstrates that removal from a Medico-Administrative office has or will have an adverse effect on the exercise of Clinical Privileges is entitled to the procedural rights contained in the Fair Hearing Plan, except to the extent that the adverse effect has resulted from the granting of an exclusive contractual

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arrangement to another Practitioner for the provision of particular clinical services.

## 2.7 **BYLAWS NOT A CONTRACT**

These Bylaws and the related manuals shall not be deemed as a contract of any kind between the Board of Trustees and the Medical Staff or any individual Member thereof. Application for, the conditions of, and the duration of Medical Staff Membership as well as any grant of Privileges to a Practitioner or an Allied Health Professional (AHP) shall not be deemed contractual in nature since the continuance of any such Privileges at the Hospital is based solely upon a Practitioner's or AHP's continuing ability to justify the exercise of such Privileges and do not obligate the Practitioner or AHP to practice at the Hospital. The Board of Trustees is obligated to use essential fairness in dealing with Medical Staff Members, Privilege holders, AHPs, and applicants for these positions and may fulfill this obligation by following the procedures specified in these Bylaws and the Related Manuals.

## **ARTICLE THREE: MEMBERSHIP CATEGORIES**

Medical Staff Membership is defined as association with the Medical Staff in one of the following categories with assumption of the associated Membership Rights and Responsibilities. There will be three categories of Staff Membership: Active, Associate and Honorary.

### 3.1 **ACTIVE STAFF**

#### 3.1-1 **QUALIFICATIONS**

The Active Staff category shall consist of Medical Staff Members who meet the General Qualifications for Membership and Privileges as established in these Bylaws, and who, for purposes of reappointment, are involved in at least twenty-five (25) patient contacts during each two (2) year reappointment cycle. This patient contact requirement may be waived by the MEC on an individual basis for Members with at least five (5) years of service in the Active category, or for those Members who otherwise document their efforts to support the Hospital's patient care mission to the satisfaction of the MEC and the Board. A patient contact is defined as an inpatient admission or consultation, referral to an inpatient admission service, evaluation and treatment of an emergency department patient, an inpatient or outpatient surgical procedure, or a diagnostic procedure interpretation at the Hospital. Pursuant to individual request and presentation of sufficient documentation, the MEC reserves the right to establish certain additional patient care activities as meeting the patient contact requirement.

In the event that an Active category Staff Member does not meet the qualifications for reappointment to the Active Staff category, but the Member is otherwise abiding by all Bylaws, Rules, Regulations, and Policies of the Medical Staff and Hospital; the Member may be appointed to another Medical Staff category if the eligibility requirements for such category are met.

The Organized Medical Staff shall consist of the Medical Staff Members in this category.

#### 3.1-2 **MEMBERSHIP RIGHTS**

Members of this category may:

- A. Attend general Medical Staff meetings and the meetings of any Committee(s) or Department to which they are assigned, as well as any Medical Staff or Hospital education programs.
- B. Vote on all matters coming before the Medical Staff or before the Department or Committee(s) to which they are assigned.
- C. Hold Medical Staff Office and sit on or Chair any Committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws or Related Manuals.

#### 3.1-3 **RESPONSIBILITIES**

Members of this category shall:

- A. Contribute to the organizational and administrative affairs of the Medical Staff.

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- B. Actively participate as requested or required in activities and functions of the Medical Staff including Committee membership, quality/performance improvement and peer review; credentialing, risk, and utilization management; medical records completion, and the discharge of other Staff functions as required
- C. Serve on the Emergency Department call schedule except that this responsibility shall be waived for Members who do not have Clinical Privileges and who also do not maintain a practice within a six (6) mile radius of the Hospital.

Those Members without Privileges who maintain a non-institutional, primarily appointment based, outpatient practice within a six (6) mile radius of the Hospital shall be required to participate in a specialty specific manner on the Emergency Department outpatient call and referral schedule. Each Department shall individually determine whether there is a need for such specialty specific outpatient call and referral schedule.

Call and referral responsibilities may be waived for Members and Privilege holders who have attained the age of at least sixty (60) and have served for ten (10) years as a Member or Privilege holder, said waiver to be determined by the MEC in its sole discretion after receiving input from the appropriate Department(s).

- D. Comply with all applicable Medical Staff or Hospital Bylaws, Rules, Regulations, Policies and procedures and pay all Staff assessments when due.

## 3.2 ASSOCIATE STAFF

### 3.2-1 QUALIFICATIONS

Members of the Associate Staff category are Medical Staff Members who meet the General Qualifications for Membership and Privileges as established in these Bylaws, but who do not meet the eligibility requirements for the Active category or choose not to pursue Active status.

### 3.2-2 MEMBERSHIP RIGHTS

Members of this category may:

- A. Attend general Medical Staff meetings and the meetings of any Committee(s) or Department to which they are assigned, as well as any Medical Staff or Hospital education programs.
- B. Serve on any Medical Staff Committee(s) except the MEC and vote on matters that come before such Committee(s).
- C. Not vote on any matters coming before the entire Medical Staff or any Department meeting.
- D. Not serve as a Medical Staff Officer, Department Chief, Department Vice-Chief, or Chair of any Committee.

### 3.2-3 RESPONSIBILITIES

Members of this category shall have the same responsibilities as Active category Members.

## 3.3 HONORARY STAFF

Members of the Honorary category shall consist of those Medical Staff Members who:

- Have retired from active hospital practice and
- Are of outstanding reputation and
- Have provided distinguished service to the Hospital.

Honorary Staff Membership is limited to those individuals recommended by the MEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time, but routine biennial reappointment is not required. Members of this category may attend Medical Staff and Department meetings as well as continuing medical education activities. They may be appointed to Committees with vote,

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but they shall not hold Clinical Privileges, hold Medical Staff Office, serve as Department Chief or Vice-Chief, or vote on matters coming before Department meetings or general Medical Staff meetings.

## 3.4 RESIDENTS

### 3.4-1 DEFINED

Residents are not Members of the Medical Staff. They are physicians in training and, as such, are not entitled to the procedural rights outlined in the Fair Hearing Plan. Residents are enrolled in postgraduate medical training under the supervision of Medical Staff Members and Privilege holders.

### 3.4-2 QUALIFICATIONS AND MATRICULATION

Residents shall have either a Medical Residency Permit or a Medical License. The selection and enrollment of Residents shall be made annually by procedures determined and implemented by the Residency Program(s) of the Hospital.

### 3.4-3 SUPERVISION

Residents in all of their training activities are under the supervision of the graduate medical education faculty, all of whom are Members of the Medical Staff who have been granted appropriate Clinical Privileges. The rights, obligations, and instructional and disciplinary procedures for Residents are delineated in the Policy and Procedure Manual of the Residency Program.

Though these physicians in training in many ways carry out the functions of Medical Staff Members, they cannot admit or discharge patients from the Hospital, hold Office in the Medical Staff organization, or vote at Department meetings; and, though they may be assigned to Hospital and Medical Staff Committees and enter into discussions, they may not vote. The role and function of Residents is further delineated in the Residency Program Policy and Procedures Manual as well as the Rules and Regulations of the Medical Staff.

## 3.5 FELLOWS

Fellows in post-residency training programs at the Hospital may be granted Staff Membership and/or Clinical Privileges if they otherwise meet all Qualifications. They may admit, care for, and discharge patients as permitted by their Clinical Privileges. In addition, Fellows may participate in training activities under the supervision of a Memorial Hospital Medical Staff Privilege Holder while learning procedures and medical skills for which they do not currently hold Privileges.

## 3.6 QUALIFICATIONS GENERALLY

Every Medical Staff Member, with the exception of Honorary Staff Members, must satisfy, at the time of appointment and continuously thereafter, the General Qualifications for Membership and Privileges as established in these Bylaws, as well as any additional qualifications that attach to the Staff category to which appointment is sought or in which Membership is held.

## ARTICLE FOUR: DELINEATION OF CLINICAL PRIVILEGES

### 4.1 PROFESSIONAL PRACTICE EVALUATION

- A. FPPE: All initially requested Privileges shall be subject to a period of FPPE (Focused Professional Practice Evaluation) as more fully described in the Hospital's FPPE policy. Such monitoring may use prospective, concurrent, or retrospective proctoring, including but not limited to chart review, tracking performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, or discussion with other healthcare individuals.
  
- B. OPPE: The Medical Staff will also engage in OPPE (Ongoing Professional Practice Evaluation) to identify trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to allow Practitioners to maintain existing Privileges, to revise existing Privileges, or to revoke any existing Privilege prior to or at the time of reappointment.

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OPPE shall be undertaken as part of the Medical Staff's routine evaluation of a Practitioner's current clinical competency. In addition, any Practitioner may be subject to FPPE when issues affecting the provision of safe, high-quality patient care are identified during the OPPE process. Decisions to assign a period of FPPE to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform any specific Clinical Privilege(s).

## **4.2 REQUESTS FOR PRIVILEGES**

Each application for appointment or reappointment to the Medical Staff or for Clinical Privileges at the Hospital must identify the specific Clinical Privileges that are being requested. Specific requests must also be submitted for Temporary Privileges and for modifications of Privileges in the interim between periodic reappointment or recredentialing. All requests for Clinical Privileges will be processed according to the Appointment/Reappointment process. Membership or application for Membership is not a requisite to application for or grant of Privileges.

## **4.3 EXERCISE OF PRIVILEGES**

Except in an emergent or disaster situation, a Practitioner providing clinical services at this Hospital by virtue of Medical Staff Membership and/or Privileges or otherwise may exercise only those Clinical Privileges specifically granted by the Board. Regardless of the level of Privileges granted, each Practitioner must obtain consultation when necessary for patient safety or when required by the Rules, Regulations, or other Policies of the Staff, any of its clinical units, or the Hospital.

## **4.4 BASIS FOR PRIVILEGES DETERMINATIONS**

Privileges are granted in accordance with prior and continuing education, training, experience, and demonstrated current competence and judgment as documented and verified in each Practitioner's credentials file. The basis for Privilege determinations for current Staff Members or Privilege holders in connection with reappointment or any requested change in Privileges shall include observed clinical performance and reports documented by the Staff's Quality Assessment activities.

## **4.5 DEPARTMENT RESPONSIBILITY**

Each Department must identify, delineate, and document the procedures and conditions that fall within its clinical area. Such documentation will reference differing levels of severity or complexity when appropriate, as well as the requisite training, the requisite experience, and other qualifications as would be appropriate to the privileging process. Such documentation must be coordinated with the Credentials Committee and approved by the MEC and the Board. This documentation must be periodically reviewed and revised because it forms the basis for delineating Privileges within the Department. Special procedures (i.e., biopsies, aspirations, endoscopies, dialysis, hyperalimentation, chemotherapy, Swan-Ganz, etc.) that may be performed at the Hospital must be delineated and required qualifications established. Privileges must be specifically requested for such special procedures.

## **4.6 CONSULTATION AND OTHER CONDITIONS**

Special requirements for consultation may be attached as a condition to the exercise of particular Privileges. This is in addition to the requirements for consultation that are specified in the Bylaws, or in the Rules, Regulations and Policies of the Staff, any of its clinical units, or the Hospital. As a part of a request for Clinical Privileges, each Practitioner pledges that in dealing with cases outside his/her own training and usual area of practice, the Practitioner will seek appropriate consultation or refer to a Practitioner who has expertise in such cases; and each Practitioner acknowledges that this requirement is circumscribed by Hospital and Medical Staff Policies and by such other special policies as may from time to time be adopted.

## **4.7 SPECIAL CONDITIONS FOR ORAL SURGEONS AND DENTISTS**

Requests for Clinical Privileges from oral surgeons and dentists are processed as specified in these Bylaws and in the Related Manuals, and in the same manner as for other Practitioners. Surgical procedures performed by oral surgeons and dentists are under the overall supervision of the Chief of Oral/Dental Surgery. Patients admitted to the Hospital for dental care shall receive the same basic medical appraisal as patients admitted for other services whether the appraisal is performed by a physician Privilege holder of the Medical Staff or an oral surgeon who is qualified to complete an admission history and physical examination and who is qualified to assess the medical risks of a proposed procedure to the patient. When the history and physical examinations

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are performed or recorded by a physician, the responsible dentist shall take into account the recommendations of this consultant in the overall assessment of the advisability of the specific procedure and in the overall assessment of the expected effect of the procedure on the patient. When a significant medical abnormality is present, the final decision concerning the advisability of any procedure must be a joint responsibility of the dentist and the medical consultant. A physician Privilege holder of the Medical Staff shall be responsible for the care of any medical problems that may be present on admission or that may arise during hospitalization of dental patients. The Chief of the Oral/Dental Surgery Department (or the President of the Medical Staff if the Chief of the Department of Oral/Dental Surgery is involved in the matter) will decide any disputed issue.

## **4.8 SPECIAL CONDITIONS FOR PODIATRISTS**

Requests for Clinical Privileges from podiatrists are processed as specified in these Bylaws and in the Related Manuals, and in the same manner as for other Practitioners. Surgical procedures performed by podiatrists are under the overall supervision of the Chief of Orthopedic Surgery. Patients admitted to the Hospital for Podiatric care shall receive the same basic medical appraisal as patients admitted for other services whether the appraisal is performed by a physician Privilege holder of the Medical Staff or a podiatrist who is qualified to complete an admission history and physical examination and who is qualified to assess the medical risks of a proposed procedure to the patient. When the history and physical examinations are performed or recorded by a physician, the responsible podiatrist shall take into account the recommendations of this consultant in the overall assessment of the advisability of the specific procedure and the overall assessment of the expected effect of the procedure on the patient. When a significant medical abnormality is present, the final decision concerning the advisability of any procedure must be a joint responsibility of the podiatrist and the medical consultant. A physician Privilege holder of the Medical Staff shall be responsible for the care of any medical problems that may be present on admission or that may arise during hospitalization of podiatric patients. The Chief of the Orthopedic Surgery Department (or the President of the Medical Staff if the Chief of the Department of Orthopedic Surgery is involved in the matter) will decide any disputed issue.

## **4.9 SPECIAL CONDITIONS FOR ALLIED HEALTH PROFESSIONAL SERVICES**

Requests to perform specified patient care services from AHPs are processed in the manner specified in the Allied Health Professional Rules and Regulations. An AHP may, subject to any licensure requirements or other limitations, exercise independent judgment within their areas of individual professional competence and participate directly in the management of patients under appropriate supervision. A Practitioner with Privileges must perform a basic medical appraisal for each patient who is admitted to the Hospital, must be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization, and must determine the potential risk and effect of any proposed surgical or special procedure on the total health status of the patient.

## **4.10 EMERGENCY PRIVILEGES**

In an emergency, any Practitioner with Clinical Privileges, regardless of his or her Medical Staff status or level of Clinical Privileges is permitted to provide any type of patient care, treatment, or services that may be necessary as a life-saving measure or to prevent serious harm, provided that the care, treatment, and services provided are within the scope of the individual's license. A Practitioner exercising Emergency Privileges is obligated to summon all necessary consultative assistance and to arrange for appropriate follow-up care.

## **4.11 DISASTER PRIVILEGES**

Disaster Privileges may be granted to practitioners by the Hospital President or Medical Staff President or their designees when the Emergency Management Plan has been activated and the Hospital is unable to handle immediate patient needs. Each practitioner with Disaster Privileges will be paired with a current Medical Staff Privilege holder who will oversee the Disaster Privileged practitioner's professional performance and practice. Disaster Privileges shall terminate when the disaster situation subsides.

Primary source verification of licensure will occur as soon as the immediate emergency situation is under control or within seventy-two (72) hours from the time the practitioner presents to the Hospital, whichever comes first. If, due to extraordinary circumstances, primary source verification of the practitioner's licensure cannot be completed within seventy-two (72) hours of the practitioner's arrival (e.g., lack of resources or no means of communication), it will be performed as soon as possible. Under these circumstances, there must be documentation of the following:

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- Reason(s) why primary source verification cannot be performed as required.
- Demonstration by the practitioner of a continuing ability to provide adequate care, treatment, and services.
- Evidence of the Hospital's attempt to perform primary source verification as soon as possible.
- Primary source verification of licensure is not required if the practitioner has not provided care, treatment, or services during the disaster situation.

## 4.12 **TEMPORARY PRIVILEGES**

### 4.12-1 **CONDITIONS**

Temporary Clinical Privileges may be granted only in the circumstances described in this section, only to an appropriately licensed Practitioner to include an Indiana Temporary Permit, only after the Practitioner has satisfied the professional liability insurance requirements of these Bylaws; and only when the information available reasonably supports a favorable determination regarding the requesting Practitioner's ability, judgment, and qualification to exercise the Privileges requested. Special requirements for consultation and reporting may be imposed by the Chief of the Department under which Temporary Privileges are granted. The Practitioner requesting Temporary Privileges should agree in writing to abide by the Bylaws, and Related Manuals, Rules and Regulations, and Policies of the Staff and Hospital in all matters relating to these Temporary Privileges. In the absence of such written agreement, the Practitioner will be presumed to have so agreed. Temporary Privileges shall not confer Medical Staff Membership and shall not confer an expectation of continued Privileges or subsequent Membership.

### 4.12-2 **CIRCUMSTANCES**

Temporary Privileges are granted by the Hospital President or authorized designee on the recommendation of the Medical Staff President or authorized designee and are granted for no more than one hundred twenty (120) days. Acceptable circumstances for which Temporary Privileges may be granted are as follows:

#### A. **To Fulfill an Important Patient Care, Treatment, or Service Need**

Temporary Privileges may be granted upon receipt of a written request for specific Temporary Privileges from a practitioner who is not an applicant for Staff Membership or Privileges when there is an important patient care need that mandates an immediate authorization to practice, including locum tenens circumstances, provided there is verification of 1) current licensure and 2) current competence. Such Privileges may be revoked at any time.

#### B. **New Applicants**

Temporary Privileges for new applicants may be granted after an application has been reviewed by the Credentials Committee and no significant concerns have been identified and after the following have been verified:

- Current licensure
- Relevant training or experience
- Current competence
- Ability to perform the Privileges requested
- Clean Criminal history background search
- A query and evaluation of the NPDB information
- No current or previously successful challenge to licensure or registration
- No involuntary termination of medical staff membership at another institution
- No involuntary limitation, reduction, denial, or loss of clinical privileges at another institution
- A complete application
- Fulfillment of any other criteria that may be required by Medical Staff Bylaws

### 4.12-3 **TERMINATION**

The Hospital President and the Medical Staff President or their designees, acting as a peer review committee, may, on the discovery of Information or the occurrence of any event of a nature which

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raises question of a Practitioner's professional qualifications or ability to exercise any or all of the Temporary Privileges granted, and after consultation with the appropriate Department Chief, terminate any or all of a Practitioner's Temporary Privileges, provided that where the life or well-being of a patient is determined to be endangered, the termination may be effected by any person empowered to impose Summary Suspension under these Bylaws. In the event of any such termination, any Hospital patients then under the care of this Practitioner will be assigned to another Practitioner by the Chief of the Department under which Privileges were granted. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

## **4.12-4 RIGHTS OF THE PRACTITIONER**

Because there is no expectation of Privileges or subsequent Membership beyond the maximum one hundred twenty (120) day period, each Practitioner seeking or granted Temporary Privileges agrees that they are not entitled to the procedural rights afforded by these Bylaws or the Fair Hearing Plan because a request for Temporary Privileges is refused or Temporary Privileges are terminated.

## **4.13 EDUCATION PRIVILEGES**

Education Privileges may be granted to those whose practice at the Hospital is in association with an educational program. Educational Privilege holders will be exempt from Emergency Department call and other specialty coverage programs and will be limited to patient care at the Hospital that is directly related to an educational program, but otherwise will have the same rights and responsibilities as other Privilege holders.

## **4.14 REFER and FOLLOW PRIVILEGES**

Refer and Follow Privileges may be granted to those who would like to follow the medical course of their outpatient practice patients who have been admitted by another Practitioner. Those who have been granted Refer and Follow Privileges may not practice at the hospital and thus may not admit, provide care, including physical exams, direct care, or enter or call in orders for inpatient care. They may not perform surgical or invasive procedures or provide interpretations of diagnostics. They may: 1) refer patients to hospitalists (when accepted for the Hospitalist Coverage Roster), and refer patients to other Privilege Holders for admission, 2) Perform outpatient preadmission H&Ps, 3) Order outpatient diagnostic tests and services, 4) Visit their referred patients in the Hospital, review their medical record and receive information concerning the patient's medical condition and treatment, but they may not make any entries in the medical record other than "social visit." 5) Consult with the attending Practitioner and, 6) Observe diagnostic or surgical procedures with the approval of the attending Practitioner or surgeon. In the absence of other qualified personnel, they may render emergency care until other qualified personnel arrive.

Refer and Follow Privilege Holders will serve on the Emergency Department outpatient call schedule as detailed in Article 3.

## **4.15 TELEMEDICINE PRIVILEGES**

Telemedicine is the provision of clinical services by Practitioners from a distance via communication technologies. Telemedicine Privilege Holders will be exempt from Emergency Department call and other specialty specific coverage programs.

## **ARTICLE FIVE: MEDICAL STAFF OFFICERS**

The Medical Staff Officers are the President, the Vice-President and the Secretary-Treasurer.

## **5.1 QUALIFICATIONS**

Each Medical Staff Officer must:

- Be a Member of the Active Staff in good standing for at least five (5) years and be actively involved in patient care at the Hospital.
- Be certified by an appropriate specialty board, or establish comparable competence.



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- Previously have served in a significant leadership position within a Medical Staff Department or Committee.
- Have participated in Medical Staff leadership training and/or be willing to participate in such training during the term of Office.
- Have no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges.
- Have demonstrated an ability to work well with others, be in compliance with the Medical Staff Code of Professional Behavior, and have excellent administrative and communication skills.
- Indicate a willingness and ability to serve.

Medical Staff Officers may not simultaneously hold a leadership position on another hospital's medical staff or in a facility that directly competes with the Hospital. Noncompliance with this requirement will result in the Officer being automatically removed from Office unless the Board determines that allowing the Officer to maintain the position is in the Hospital's best interest. The Board shall have the discretion to determine what constitutes a leadership position at another hospital or facility.

## 5.2 **TERM OF OFFICE**

The term of Office for Medical Staff Officers is two (2) years. Officers assume Office on the first day of February following their election, except that an Officer elected or appointed to fill a vacancy assumes Office immediately upon election or appointment. Except for resignation or removal from Office, each Officer serves until the end of the term or until a successor is elected and assumes Office. An individual may not be re-elected to the same Office for more than two (2) consecutive terms, but there is otherwise no limit to the number of terms that an individual may serve.

## 5.3 **VACANCIES OF OFFICE**

The MEC shall fill vacancies of Office during the Medical Staff year, except the Office of the Medical Staff President. If there is a vacancy in the Office of the Medical Staff President, the Vice President shall become Medical Staff President and serve the remainder of the original term. Anyone appointed to fill a vacancy in the Office of Vice President or Secretary-Treasurer will serve pending the outcome of a special election which is to be conducted as expeditiously as possible except that the MEC may determine not to call a special election if regular elections are to be held in the near future.

## 5.4 **ELECTION OF OFFICERS**

### 5.4-1 **PRESIDENT, VICE PRESIDENT, AND SECRETARY-TREASURER**

#### A. **Nomination**

The Leadership and Succession Committee shall offer at least one nominee for each available position. The Committee, composed of three (3) Active Staff Members, shall convene in September of the election year. Nominations must be announced and the names of the nominees distributed to all Members of the Active Medical Staff at least 30 days prior to the election.

A petition signed by at least ten (10) Members of the Active Staff may add additional nominees to the ballot. Such petition must be submitted to the Medical Staff President at least fourteen (14) days prior to the election in order for the nominee(s) to be placed on the ballot. The Leadership and Succession Committee shall determine that each nominee meets the qualifications required in these Bylaws before that nominee is placed on the ballot.

#### B. **Election**

New Officers shall be elected at least one month prior to the expiration of the term of the current Officers. Only Members of the Active Medical Staff shall be eligible to vote. The election mechanisms that may be considered for utilization include paper ballots and electronic voting via computer, fax, or other technology. No proxy voting will be permitted. The nominee for each Office who receives the greatest number of votes will be declared the winner. In the event of a tie vote, a repeat vote will be taken within 14 days on a ballot of the tied candidates and repeated if necessary until one candidate receives a greater number of votes and is declared the winner.

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## 5.5 RESIGNATION AND REMOVAL FROM OFFICE

### 5.5-1 RESIGNATION

Any Medical Staff Officer may resign at any time by giving written notice to the MEC. Such resignation takes effect on either the date of receipt by the MEC or on the date specified in the resignation notice.

### 5.5-2 REMOVAL OF MEDICAL STAFF OFFICER

Removal of a Medical Staff Officer may be effected by a two-thirds (2/3) majority vote by secret ballot of the Members of the Active Staff who are present; such vote being taken at a Special Meeting called for that purpose. Active category Staff Members will be given at least ten (10) days notice of the meeting. Permissible basis of removal of a Medical Staff Officer includes:

- A. Failure to perform the duties specified in these Bylaws or failure to perform any action or duties which may be requested by the MEC or the Board of Trustees.
- B. Failure to act or carry out responsibilities in such a way as to enable the Medical Staff to operate in an orderly manner.
- C. Any involuntary reduction, suspension or revocation of the Membership status or of the Clinical Privileges of the Officer involved.

Any dismissal or removal from Office shall in no way affect the Officer's Clinical Privileges, nor would the Officer be afforded any rights under the Fair Hearing Plan on account of such removal.

## 5.6 DUTIES OF OFFICERS

The authority and responsibilities including specific functions and tasks of Medical Staff Officers are set forth in the Medical Staff Organizational Manual. The general duties of the Medical Staff Officers are outlined in this section.

### 5.6-1 DUTIES OF THE PRESIDENT OF THE MEDICAL STAFF

The President shall represent the interest of the Medical Staff to the MEC and the Board, and shall fulfill the duties specified in the Medical Staff Organizational Manual.

### 5.6-2 DUTIES OF THE VICE PRESIDENT

In the absence of the President, the Vice President shall assume all the duties and have the authority of the President. The Vice President shall perform additional duties to assist the President as requested, as well as perform other duties as specified in the Medical Staff Organizational Manual. The Vice President also serves on the Medical Staff Peer Review Committee.

### 5.6-3 DUTIES OF THE SECRETARY-TREASURER

The Secretary-Treasurer will collaborate with the Hospital's Medical Staff Office, ensure maintenance of minutes, attend to correspondence, act as Medical Staff treasurer, and coordinate communication within the Medical Staff. The Secretary-Treasurer shall perform additional duties to assist the Medical Staff President as requested.

## ARTICLE SIX: CLINICAL DEPARTMENTS AND MEDICAL EDUCATION

### 6.1 DESIGNATION

#### 6.1-1 CURRENT CLINICAL DEPARTMENTS

The current clinical Departments are described in the Medical Staff Organizational Manual.

#### 6.1-2 FUTURE CLINICAL DEPARTMENTS

In order to promote organizational efficiency and quality patient care, the MEC will periodically review the Departmental structure and may make recommendations to the Board concerning creating new or combining Departments or creating distinct sections within a Department. A group of Practitioners who believe they satisfy the criteria for Departmental or Section designation set forth below may at any time petition the MEC in writing and with appropriate supporting documentation for such designation. The MEC will consider the request and forward its recommendation to the Board for final decision.

#### 6.1-3 CRITERIA TO QUALIFY AS A CLINICAL DEPARTMENT

The following criteria will be used by the MEC and the Board in making recommendations and taking action with respect to Departmental designations:

- A. The area of practice represents a major general, distinct field of medical practice at the Hospital, or is a field that crosses clinical disciplines.
- B. A sufficient number of Practitioners, actively engaged in that area of practice, are available to participate in accomplishing the functions assigned to Departments.
- C. The level of clinical activity is substantial enough to warrant imposing the responsibility to accomplish those functions on a routine basis.

#### 6.1-4 CRITERIA TO QUALIFY AS A SPECIALTY SECTION

The following criteria will be used by the MEC and the Board in making recommendations and taking action with respect to Section designations:

- A. The area of practice is an established, professionally recognized specialty/subspecialty field within the general field of a Department and is a significant area of practice within that Department at this Hospital. ("Significant" means that specialists in that area devote most of their time to that area of practice rather than having a more broadly based practice.)
- B. A sufficient number of Practitioners, actively engaged primarily in that area, are available to participate in accomplishing the functions assigned to Sections.
- C. The level of clinical activity is substantial enough to warrant imposing the responsibility to accomplish those functions on a routine basis.

### 6.2 REQUIREMENTS FOR ASSIGNMENT TO A DEPARTMENT

- A. Each Department is a separate organizational component of the Medical Staff, and each Staff Member or Privilege holder will be assigned to the one Department that most closely reflects the Member or Privilege holder's professional training and experience and the clinical area in which the majority of the Member or Privilege holder's practice is concentrated. Clinical Privileges are independent of Department assignment.
- B. It is recognized that circumstances may exist whereby a Member or Privilege holder desires affiliation with a different Department than was initially assigned. Re-assignment to another Department may be granted subsequent to written request for transfer if the following conditions are met:

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- Training and experience of the Member or Privilege Holder closely reflect the clinical area of the requested Department.
- The Chief of the requested Department approves the transfer.
- The Credentials Committee approves the transfer.
- The Member or Privilege Holder remains in the new Department for a minimum of two (2) years.

C. Exercise of Clinical Privileges is subject to any applicable Rules and Regulations and Policies of the Department in which Privileges are received and is subject to the authority of that Department Chief.

## 6.3 **FUNCTIONS OF CLINICAL DEPARTMENTS**

### 6.3-1 **GENERALLY**

The clinical Departments fulfill certain clinical, administrative, quality assessment/assurance, collegial, and educational functions. Through election to Staff-wide Offices and participation by Department representatives on Committees; Staff Members affiliated with each Department perform these same functions on a multidisciplinary, Medical Staff-wide, and Hospital-wide basis. Subject to the approval of the MEC and the Board, each Department will formulate its own written policies for the conduct of its affairs and the discharge of its responsibilities, all of which must be consistent with these Bylaws, the Related Manuals, the Staff Rules and Regulations, and Hospital Policies.

### 6.3-2 **CLINICAL FUNCTIONS**

Each Department will:

- A. Develop patient care standards, policies, procedures, and practices within the Department and monitor the adherence by Medical Staff Members and Privilege holders to those standards, policies, procedures, and practices that are relevant to the various clinical disciplines under the Department's jurisdiction;
- B. Provide an inter-Departmental forum for matters of clinical concern and for resolving clinical issues arising out of the interface between the activities of Department members and the activities of other patient care and administrative services; and
- C. Develop, with assistance from the various specialists and sub-specialists, criteria for use in making credentialing recommendations on initial appointments, reappointments, and grants of Clinical Privileges.

### 6.3-3 **ADMINISTRATIVE FUNCTIONS**

Each Department will:

- A. Assure that its members contribute their professional views and insights to the formulation of Departmental, Medical Staff, and Hospital policies and procedures;
- B. Communicate formulated policies and procedures back to its members for implementation;
- C. Coordinate the professional services of its members with those of other Departments and with Hospital and Medical Staff support services; and
- D. Make recommendations to the MEC, Hospital President, and other components, as appropriate, concerning the short-term and long-term allocation of resources and provision of services by the Hospital and Department.

### 6.3-4 **QUALITY ASSESSMENT/ASSURANCE FUNCTIONS**

Each Department will:

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- A. Review Quality Assessment and utilization data and findings pertinent to the Department, and make recommendations or take action as appropriate; and
- B. Conduct special studies of inputs, processes, and outcomes of care; perform specified monitoring activities including mortality reviews, and otherwise participate as required in the Quality Assessment program.

## **6.3-5 EDUCATIONAL AND PEER REVIEW FUNCTIONS**

Each Department will serve as the most immediate peer group for peer review, teaching, continuing education, and sharing new knowledge relevant to the practice of Department members; and will provide consultative advice in its clinical area to members of other Departments.

## **6.4 DEPARTMENT OF MEDICAL EDUCATION**

The Department of Medical Education is an administrative, not a clinical Department. Its functions are limited to organization and administration of medical education at the Hospital.

# **ARTICLE SEVEN: OFFICERS OF CLINICAL DEPARTMENTS**

## **7.1 QUALIFICATIONS OF OFFICERS**

Each Department will have a Chief and Vice-Chief; each of whom must:

- A. Be a Member of the Active Staff and a member of the applicable Department and remain in Good Standing throughout their term.
- B. Be certified by an appropriate specialty board or establish comparable competence.
- C. Be recognized for current clinical ability in one of the clinical areas covered by the Department.
- D. Have demonstrated executive and medico-administrative abilities through training and/or experience.
- E. Willingly and faithfully discharge the functions of the Office and work with the other Staff and Department Officers, the Hospital President, and the Board and its Committees.

## **7.2 ROLES AND RESPONSIBILITIES**

### **7.2-1 The Department Chief shall:**

- A. Monitor clinically related activities of the Department;
- B. Monitor administratively related activities of the Department unless otherwise provided by the Hospital;
- C. Maintain continuing surveillance of the professional performance of all Practitioners in the Department;
- D. Recommend to the Medical Staff criteria for Clinical Privileges that are relevant to the care provided in the Department;
- E. Recommend Clinical Privileges for each member of the Department;
- F. Assess, and recommend to the relevant Hospital authority, off-site sources for patient care, treatment, or services that are not provided by the Department or the Hospital;
- G. Facilitate the integration of the Department into the primary functions of the Hospital;

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- H. Facilitate the coordination and integration of interdepartmental and intradepartmental services;
- I. Coordinate the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;
- J. Make recommendations concerning the availability of a sufficient number of qualified and competent personnel to provide care, treatment, and services;
- K. Make recommendations concerning the qualifications of and competence of Departmental personnel who are not Licensed Independent Practitioners and who provide patient care, treatment, or services;
- L. Facilitate the continuous assessment and improvement of the quality of care, treatment, and services;
- M. Cooperate in the maintenance of quality control programs, as appropriate;
- N. Cooperate in orientation and continuing education of all members of the Department; and
- O. Advise on space and other resources needed by the Department.

## **7.2-2 The Vice-Chief shall:**

- A. In the absence of the Department Chief, act on all matters with the same authority as the Chief;
- B. In the absence of the Department Chief, attend any MEC meeting with vote; and
- C. Review cases involving the applicable department referred for Peer Review.

## **7.2 NOMINATION AND APPOINTMENT FOR THE OFFICE OF DEPARTMENT CHIEF AND VICE-CHIEF**

Each Department will be responsible for providing a nominee for Chief and for Vice-Chief, elected by Department members, to the MEC no later than the November meeting of the MEC. If the MEC approves the nominees, the names of the Department Chief and Vice-Chief so appointed will be forwarded to the Board of Trustees. The MEC may also refer the matter back to the Department for prompt reconsideration.

## **7.3 TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTION**

The term of Office for the Department Chief and Vice-Chief is two-years, unless the Chief or Vice-Chief resigns or is removed from Office. The Department Chief and Vice-Chief assume Office on the first day of the Medical Staff year following appointment, except that an Officer appointed to fill a vacancy assumes Office immediately upon appointment. The Department Chief and Vice-Chief are eligible for re-election and re-appointment.

## **7.4 RESIGNATION AND REMOVAL**

### **7.4-1 RESIGNATION**

A Department Chief or Vice-Chief may resign at any time by giving written notice to the MEC. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or on any later time specified therein.

### **7.4-2 REMOVAL**

Removal of a Department Chief or Vice-Chief may be effected by a two-thirds (2/3) majority vote of the Active Staff Members of the Department who are in Good Standing. Removal becomes effective following ratification by the MEC. Permissible basis of removal of a Chief or Vice-Chief include:

- A. Failure to perform the duties specified in these Bylaws or the Related Manuals.

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- B. Failure to perform any action or duties which may be requested by the MEC or the Board of Trustees.
- C. Failure to act or carry out responsibilities in such a way as to enable the Medical Staff to operate in an orderly manner.
- D. Any involuntary reduction, suspension, or revocation of Medical Staff Membership or of the Clinical Privileges of the Officer involved.

Any dismissal or removal from Office shall in no way affect the Officer's Membership Status or Clinical Privileges, nor would the Officer be afforded any rights under the Fair Hearing Plan on account of such removal.

## 7.5 **VACANCIES**

A vacancy in the Office of Department Chief is filled by the MEC by appointment of the Vice Chief to the Office of Department Chief for the remainder of the original term. Department members shall elect a nominee to fill any vacancy in the Office of Vice-Chief. The name of the nominee is forwarded to the MEC which may appoint the nominee to the Office of Department Vice-Chief and forward the name to the Board or refer the matter back to the Department for prompt reconsideration.

## 7.6 **RESPONSIBILITY, AUTHORITY AND REPORTING OBLIGATIONS OF DEPARTMENT CHIEF**

### 7.6-1 **RESPONSIBILITY AND AUTHORITY**

The Department Chief has the responsibility and authority to do everything necessary to carry out the functions delegated to him and to the Department by the Board, the MEC, the Medical Staff Rules and Regulations, and these Bylaws and the Related Manuals. The Vice Chief will exercise this responsibility and authority in the absence of the Department Chief.

### 7.6-2 **REPORTING OBLIGATIONS**

Each Department Chief will report:

- A. On Departmental activities at all regularly scheduled MEC, Department, and Medical Staff meetings.
- B. Whenever necessary or requested, to the Medical Staff President on matters of some immediacy where action to coordinate clinical services, to maintain quality, or to assure patient safety is at issue.
- C. To the Hospital President on issues relating to administrative duties for supervision of Hospital personnel, proper functioning of equipment, and efficient scheduling.
- D. To the MEC, the Hospital President, and the Board, on issues relating to the allocation of resources to the various Departments, budgetary items, and similar concerns.

### 7.6-3 **SPECIFIC ROLES AND RESPONSIBILITIES**

The specific roles and responsibilities of Department Chief and Vice-Chief are more fully delineated in the Medical Staff Organizational Manual.

## **ARTICLE EIGHT: FUNCTIONS AND COMMITTEES**

### 8.1 **FUNCTIONS OF THE STAFF**

The required functions of the Medical Staff are specified below. These functions shall be performed through assignment to the Staff as a whole, to Departments, to other clinical units, to Staff Committees, to Staff Officers, to other individual Staff Members, or to interdisciplinary Hospital Committees with participation of Medical Staff Members.

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- A. Govern, direct, and coordinate the Medical Staff organization and its various functions.
- B. Plan, conduct, coordinate, and evaluate the Medical Staff components of the Quality Assessment programs.
- C. Conduct, coordinate, and evaluate the effectiveness of monitoring activities, including:
  - Tissue, blood usage, mortality, morbidity, and antibiotic and other drug use reviews;
  - Analysis of autopsy reports, and analysis of unexpected clinical occurrences;
  - Fulfillment of consultation requirements; and
  - Compliance with the Bylaws, Related Manuals, Rules, Regulations, Policies and Procedures of the Staff and Hospital.
- D. Conduct, coordinate, and evaluate the effectiveness of, or oversee the conduct of utilization review programs.
- E. Conduct, coordinate, and evaluate the effectiveness of special studies of the inputs, processes, and outcomes of patient care.
- F. Monitor and evaluate care provided in and develop clinical policy for:
  - Intensive care units;
  - Coronary and other special care units;
  - Patient care support services, such as respiratory therapy and physical therapy; and
  - Emergency and other ambulatory care services.
- G. Conduct, coordinate, and act on credentials investigations and recommendations regarding Staff Membership, grants of Clinical Privileges, Corrective Action, and specified services by Allied Health Professionals.
- H. Provide and evaluate continuing education opportunities that are responsive, when appropriate, to Quality Assessment Program findings and to new state-of-the-art developments pertinent to clinical practice at the Hospital.
- I. Plan, conduct, coordinate, and evaluate the training of students and residents.
- J. Provide medical direction to the Hospital's professional library services.
- K. Develop and review policies and practices on, and maintain surveillance over the completeness, timeliness, and clinical pertinence of medical and related records.
- L. Develop and maintain surveillance of drug utilization policies and practices.
- M. Participate in preventing, investigating, and controlling hospital-acquired infections and participate in monitoring the infection control program.
- N. Participate in planning for response to fire and other disasters, for the growth and development of the Hospital, and for the provision of the services required to meet the needs of the community.
- O. Direct Staff organizational activities, including Medical Staff Bylaws review and revisions and Staff Officer and Committee membership nominations.
- P. Act as liaison with the Board and Administration, and review and maintain the Medical Staff related aspects of accreditation, and review and participate in the maintenance of other required licenses and certifications.



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- Q. Coordinate the care provided by Practitioners with the care provided by nursing and support services and with the activities of other patient care and administrative services.

## 8.2 **PRINCIPLES GOVERNING COMMITTEES**

### 8.2-1 **MEDICAL EXECUTIVE COMMITTEE**

The MEC is empowered to act for the Organized Medical Staff between meetings of the Organized Medical Staff. It meets at least 10 times per year and communicates its discussions and actions that relate to or define Staff Policies, Rules, or positions by monthly summary reports made available to all Medical Staff Members and Privilege holders.

#### A. **COMPOSITION**

The MEC consists of the President, Vice President, and Secretary-Treasurer of the Medical Staff and the Chief of each of the Medical Staff Departments. Non-voting members include the Chair of the Credentials Committee, Director of Medical Education, Program Director of the Family Medicine Residency, the Hospital President, the Hospital Chief Operating Officer, the Vice President for Medical Affairs, and the Vice President of Nursing.

#### B. **FUNCTION**

- Receives, coordinates and acts upon the written reports and recommendations from Officers, Departments, Committees, and other assigned activity groups concerning the functions assigned to them and the discharge of their delegated responsibilities.
- Coordinates the activities of and policies adopted by the Staff, the Departments and other clinical units and Committees.
- Accounts to the Board and to the Staff concerning the overall quality and efficiency of patient care at the Hospital.
- Takes reasonable steps to ensure professional and ethical conduct and competent clinical performance on the part of Staff Members and Privilege holders including evaluation, investigation, or other action when Corrective Action has been requested.
- Requests evaluations of Practitioners Privileged through the Medical Staff process in instances where there is concern about a Practitioner's ability to perform requested or granted Privileges.
- Makes recommendations on medical, administrative, and Hospital management matters.
- Informs the Medical Staff about the accreditation program and the accreditation status of the Hospital.
- Represents and acts on behalf of the Medical Staff, subject to such limitations as may be imposed by the Organized Medical Staff.
- Prepares a monthly summary report of its discussions and actions for the Staff, the Board, and Hospital Management.
- Approves all physician appointments to Medical Staff Committees.
- Reviews the recommendations of the Credentials Committee concerning Appointment and Reappointment to the Medical Staff and the delineation of individual Clinical Privileges.
- Makes recommendations to the Board concerning Medical Staff Membership status.

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- Makes recommendations to the Board concerning the delineation of Privileges for each Practitioner Privileged through the Medical Staff process.
- Makes recommendations to the Board concerning the Medical Staff organizational structure and the process used to review credentials and delineate Privileges.
- Makes recommendations to the Board concerning the MEC's review of, and actions taken on reports of Medical Staff Committees, Departments, and other assigned activity groups.
- Ensures that each Resident is adequately supervised in their patient care responsibilities by a Medical Staff Privilege holder who has been granted appropriate Clinical Privileges, as more fully described in the Residency Program Policy and Procedures Manual. The MEC shall regularly communicate with the Hospital's Family Medicine Residency Program about the safety and quality of patient care, treatment, and services provided by Residents, and the related educational and supervisory needs of Residents. The MEC shall periodically communicate with the Board of Trustees about the educational needs and performance of Residents.

## **8.2-2**      **SUBSTITUTION**

The MEC may, subject to Board approval, at any time it deems necessary and desirable for the proper discharge of the functions required of the Staff by these Bylaws and the Related Manuals and by the bylaws and policies of the Hospital, establish, eliminate, or merge Staff Committees, change the functions of a Staff Committee, or assign any function to another organizational component. For each Standing Committee, the composition and function are set forth in the Medical Staff Organizational Manual.

## **8.2-3**      **REPRESENTATION ON HOSPITAL COMMITTEES**

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

## **8.2-4**      **EX OFFICIO MEMBERS**

The Hospital President or designee is a member of the MEC and of all other Standing and special Committees of the Staff, ex officio and without vote.

## **8.2-5**      **ACTION THROUGH SUBCOMMITTEES**

Any Standing Committee may choose to perform any of its specifically designated functions by constituting any number of its members as a Subcommittee for that purpose, reporting such action to the MEC in writing. Any such Subcommittee may include individuals in addition to members of the Standing Committee. Such additional members are appointed by the Committee Chair after consultation with the Medical Staff President or with the Hospital President when administrative staff appointments are to be made.

## **8.2-6**      **COMPOSITION**

In addition to Staff Members, a Medical Staff Committee may include AHPs or representation from Administration, Nursing Services, Medical Records, or such other Hospital department as is appropriate to the function(s) to be discharged.

## **8.2-7**      **APPOINTMENT**

Except as otherwise expressly provided and subject to MEC approval, the Medical Staff President appoints Committee members and Chairs. Non-Medical Staff appointees are subject to the approval of the Hospital President.

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## 8.2-8 TERM, PRIOR REMOVAL AND VACANCIES

A Committee member serves a two (2) year term, unless resignation or removal from the Committee occurs. Reappointment is allowed and encouraged.

A Committee member, except one serving ex officio, may be removed for failure to maintain Good Standing as a Member of the Staff or for failure to satisfy the attendance requirements specified in these Bylaws and the Related Manuals or by action of the MEC or the Board. A vacancy in any Committee is filled for the unexpired portion of the term in the same manner in which an original appointment is made. Any ex officio membership on a Staff Committee ceases when the designated position, which is the basis of ex officio membership, ceases.

## ARTICLE NINE: MEETINGS

### 9.1 MEDICAL STAFF YEAR

For purposes of the business of the Medical Staff, the Medical Staff year will commence each year on the first day of February.

### 9.2 MEDICAL STAFF MEETINGS

#### 9.2-1 REGULAR MEETINGS

There will be an annual meeting of the Medical Staff. Departments must meet at least annually. The frequency of Committee meetings is as specified in the Organizational Manual. Each Member of the Medical Staff is strongly encouraged to attend meetings of the Department and any Committee(s) to which they are assigned.

#### 9.2-2 SPECIAL MEETINGS

A Special Meeting of the Medical Staff may be called by the Medical Staff President, the MEC, or by petition of ten percent (10%) of the Members of the Active Staff in Good Standing. A meeting of any Department or Committee may be called by the Chief/Chair of the respective Department/Committee, the MEC, the Medical Staff President, or one-third of the group's current members in Good Standing.

### 9.3 SPECIAL APPEARANCES AND SPECIAL CONFERENCES

- A. Whenever a patient's clinical course of treatment is scheduled for discussion at a Staff, Department, or Committee meeting, a Practitioner who was involved in the care of the patient should be notified and invited to present the case.
- B. Whenever a Staff or Department education program or clinical conference is prompted by findings of review, evaluation, or monitoring activities, the Practitioner(s) whose performance pattern(s) prompted the program will be notified of the time, date, and place of the program, of the subject matter to be covered, and of its special applicability to the Practitioner's medical practice. Attendance is mandatory for any Practitioner who is so notified.
- C. Whenever a pattern of apparent or suspected deviation from standard clinical practice by a Practitioner is identified, the Medical Staff President or the applicable Department Chief may require this Practitioner to confer individually with a Standing or ad hoc Committee that is considering the matter. The Practitioner will be given at least five (5) days prior notice of the conference, to include the date, time, and place; a statement of the issue involved, and that the Practitioner's appearance is mandatory. Failure of the Practitioner to appear at any such conference, unless excused by the MEC upon showing of good cause, may result in Summary Suspension of all or such portion of the Practitioner's Clinical Privileges as the MEC may direct. A Suspension under this Section is for investigative purposes and will remain in effect until the matter is resolved by subsequent action of the MEC or the Board.

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## 9.4 **MEETING PROCEDURES**

Notice, quorum, minutes, and agenda requirements for meetings are set forth in the Medical Staff Organizational Manual.

## **ARTICLE TEN: CORRECTIVE ACTION**

### 10.1 **CRITERIA FOR INITIATING ROUTINE CORRECTIVE ACTION**

When reliable Information indicates that a Member or Practitioner is considered to not meet the applicable standard of care established by the Medical Staff, to be disruptive to the operation of the Hospital, to be disruptive to the delivery of quality medical care, or to violate Hospital or Medical Staff rules, regulations, or policies, and that Corrective Action against such Member or Practitioner may be necessary or advisable; any Member of the Medical Staff may request that Corrective Action be considered against such Member or Practitioner. All requests for Corrective Action must be in writing, submitted to the MEC, and supported by references to the specific activities or conduct which constitutes grounds for the request. The Medical Staff President will promptly notify the Hospital President of all such requests.

#### 10.1-1 **DISCRETIONARY INTERVIEW PRIOR TO CORRECTIVE ACTION**

Whenever Corrective Action, if based on questions of competence or professional conduct, could result in the revocation, reduction, or suspension of Medical Staff Membership or Clinical Privileges, an investigation will be initiated by the Medical Staff President on behalf of the MEC as soon as practicable for the purpose of gathering information on the matter. Prior to the initiation of Corrective Action, the Member or Practitioner against whom Corrective Action has been requested shall have an opportunity for an interview with the MEC unless such interview would limit the MEC's ability to take timely and efficient action. This interview will be initiated by Special Notice to the Member or Practitioner with copies transmitted to the President of the Medical Staff and the Hospital President. At such interview, the Member or Practitioner shall be informed of the general nature of the accusations and shall be invited to discuss, explain, or refute them. This interview shall not constitute a Hearing, shall be preliminary in nature, and none of the procedural rights provided in these Bylaws or the Fair Hearing Plan with respect to Hearings shall apply. As well, the Member or Practitioner will not have the right to have legal counsel present at this interview. A written record reflecting the substance and conclusion of the interview should be made and transmitted to the Member or Practitioner, the President of the Medical Staff, the Hospital President, and the Member or Practitioner's credentials file. If the Member or Practitioner fails to respond to the Special Notice or declines to participate in the interview, Corrective Action may immediately proceed.

#### 10.1-2 **INVESTIGATION**

After deliberation, the MEC may either act on the request for Corrective Action or direct that an investigation be initiated concerning the matter. The MEC may conduct such investigation itself or may assign this task to a Medical Staff Officer, Department, Standing or ad hoc Committee, or other organizational component of the Medical Staff on its behalf. This investigative process is not a Hearing as that term is used in the Fair Hearing Plan. It may include a consultation with the Member or Practitioner involved or with the individual or group making the request or with other individuals who may have knowledge of the matter. If the investigation is accomplished by a group or individual other than the MEC, that group or individual must forward a written report of the investigation to the MEC as soon as is feasible after the assignment to investigate has been made.

In its discretion, the MEC may at any time, and shall at the request of the Board, terminate the investigative process and proceed with the action it determines to be appropriate under the circumstances.

#### 10.1-3 **MEC ACTION**

As soon as feasible after the conclusion of the investigative process, if any, but in any event within fifteen (15) working days after receipt of the investigative report, the MEC may reject or modify the request for Corrective Action; issue a warning, admonishment, or a letter of reprimand; impose terms of probation or a requirement for consultation; or recommend to the Board a reduction, modification, restriction, suspension, or revocation of Clinical Privileges; recommend to the Board that an already imposed Summary Suspension of Clinical Privileges be terminated, modified, or

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sustained; recommend to the Board that the individual's Staff Membership be suspended or revoked; or take or recommend such other action as it deems appropriate under the circumstances.

Consistent with Section 2.1-1(H), above, no member of the MEC with an actual conflict of interest or with a potential conflict of interest sufficient to render the member incapable of making a determination that is reasonably based upon the pertinent circumstances and that is in the best interests of patient safety, the Medical Staff, and the Hospital, shall participate in the MEC's deliberation or vote regarding potential corrective action.

## **10.1-4 PROCEDURAL RIGHTS**

Any recommendation by the MEC that would be deemed to be an Adverse Action as described in the Fair Hearing Process within these Bylaws, may entitle the affected Member or Practitioner to certain Fair Hearing procedural rights as provided for in the Fair Hearing Plan. Certain actions that if based on questions of competence or professional conduct, including letters of admonition, warning, or reprimand, but which do not result in a restriction of Membership or Clinical Privileges, do not give rise to Fair Hearing rights.

## **10.1-5 BOARD ACTION**

- A. Subject to a Member or Practitioner's procedural rights as set forth in the Fair Hearing Plan, the MEC's recommendation will be transmitted to the Board together with all supporting documentation. If the Board's initial action on any such recommendation represents a substantive change from the MEC's recommendation, the matter will be submitted to a joint conference committee composed of three (3) members from the Medical Staff who are appointed by the President of the Medical Staff and three (3) members from the Board who are appointed by the Chairman of the Board, for review and recommendation before the Board takes final action.
- B. If, in the Board's determination, the MEC fails to act in a timely manner in processing and recommending action on a request for Corrective Action, it may, after notifying the MEC of its intent and allowing a reasonable period of time for response, take action on its own initiative.
- C. Any non Adverse decision is deemed to be the Board's final action. If the Board's decision is an Adverse Action in any respect, the Hospital President shall notify the Member or Practitioner by Special Notice within a reasonable period of time of the Adverse determination. The notice shall state the basis of the Adverse determination and shall include information concerning Fair Hearing rights, if any, as required by the Fair Hearing Plan or these Bylaws.

## **10.2 SUMMARY SUSPENSION**

Whenever there is a good faith belief that the conduct or activities of a Member or Practitioner pose a threat to the life, health, or safety of any patient, employee, staff, visitor, or other person present at the Hospital; and that failure to take prompt action may result in imminent danger to the life, health, or safety of any such person; the MEC or the Board or any two (2) of the following individuals, acting as a Peer Review Committee, (i.e., the President of the Staff, the applicable Department Chair, the Hospital President, or their respective designated representatives) has the authority to Summarily Suspend the Medical Staff Membership status and/or Summarily Suspend or restrict all or any portion of the Clinical Privileges of such Member or Practitioner. Summary Suspension is effective immediately upon imposition. The reasons for and notice of Summary Suspension shall be in writing and shall be promptly presented to the Member or Practitioner. Such a Suspension shall be for the purpose of investigation only and shall not imply any final findings of responsibility for the matter associated with the Suspension. Unless otherwise indicated by the terms of the Summary Suspension, the Practitioner's patients, if not assumed by the Practitioner's practice group, shall be promptly assigned to another Medical Staff Privilege holder by the Department Chief or by the President of the Medical Staff, considering where feasible, the wishes of the patient in the choice of a substitute.

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## **10.2-1 MEC ACTION**

As soon as possible, but not more than fourteen (14) days after Summary Suspension has been imposed, a meeting of the MEC will convene to review and consider the action taken. The MEC, in its sole discretion, may request that the Member or Practitioner attend such meeting and make a statement concerning the issues under investigation, on such terms and conditions as the MEC may impose, though in no event shall any meeting of the MEC, with or without the Member or Practitioner, constitute a Hearing within the meaning of the Fair Hearing Plan, nor shall any procedural rules apply. The MEC may continue, modify, or terminate the Summary Suspension. If Summary Suspension is terminated within fourteen (14) days of its imposition without further recommendation for Adverse Action, there will be no right to a Hearing and there will be no report to the National Practitioner Data Bank, unless otherwise required by the circumstances and applicable federal law. If the MEC fails to terminate or determines to continue Summary Suspension beyond fourteen (14) days, or recommends other Adverse Action, the Member or Practitioner shall be given Special Notice with an explanation of such determination or recommendation and with information concerning Fair Hearing rights as required by the Fair Hearing Plan or these Bylaws.

## **10.2-2 BOARD ACTION**

Any MEC recommendation to terminate or modify Summary Suspension to a lesser sanction not triggering procedural rights under the Fair Hearing Plan is transmitted immediately to the Board, together with all supporting documentation. The terms of Summary Suspension as originally imposed remain in effect pending a final decision by the Board.

## **10.3 AUTOMATIC SUSPENSION**

Staff Membership and/or Clinical Privileges will be Automatically Suspended whenever a Member's or Privilege holder's Indiana medical license is revoked, restricted, limited, or placed on probation. The scope of Automatic Suspension will be dependent on the nature of the restriction, limitation, probation, suspension, or revocation and will be effective upon, and for at least the term of the restriction, limitation, probation, suspension, or revocation; however, those with limitations or restrictions placed on their license may continue to hold Membership if recommended by the MEC and approved by the Board. The MEC may recommend such further Corrective Action as is appropriate to facts disclosed by investigation.

- A.** Failure to remain a Qualified Provider under the Indiana Medical Malpractice Act (I.C.34-18) will result in Automatic Suspension of a Practitioner's Clinical Privileges until such qualification under the Act is reestablished.
- B.** If a Practitioner's DEA certificate or other controlled substances certificate is suspended, revoked, restricted, limited, or placed on probation due to intentional controlled substance diversion, Clinical Privileges may be Automatically Suspended. It is the responsibility of each Member and each Privilege Holder to promptly notify the President of the Medical Staff of any suspension, revocation, restriction, or limitation of their DEA certificate or other controlled substances certificate. The decision to institute Automatic Suspension in such situation may be emergently made by the Medical Staff President, who may instead bring the issue to the MEC.
- C.** If a Practitioner's Medicare or Medicaid provider status is revoked or suspended, Clinical Privileges, including admitting Privileges, will be Automatically Suspended until such suspension or revocation of Medicare or Medicaid provider status is lifted and the applicable provider status is restored. Such suspension or revocation does not preclude further Corrective Action from being initiated.

A practitioner is required to immediately advise the Hospital President in writing of any revocation, suspension, or change in the Practitioner's Medicare or Medicaid provider status. Failure to notify the Hospital President in a timely manner may be grounds for Corrective Action.

- D.** A Practitioner's Clinical Privileges will be Automatically Suspended after written warning of delinquency for failure to complete medical records within the time period specified in the Medical Staff Rules and Regulations. Such Suspension is effective on the date indicated in the written warning and continues until the delinquent medical records are completed or until such other time as

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provided in the Medical Staff Bylaws and Rules and Regulations. In the case of Automatic Suspension for medical records deficiencies, failure to complete, within 90 days of the imposition of said Automatic Suspension, those actions which would be required in order to have such Suspension lifted, will be considered voluntary resignation from the Medical Staff and voluntary relinquishment of Privileges.

- E. There shall be no hearing or appeal for Automatic Suspension except on the grounds that the reason for such Suspension did not exist or that the reason no longer exists or that any waiting period for reinstatement has expired.

## ARTICLE ELEVEN: FAIR HEARING PROCESS

### 11.1 GROUND FOR A HEARING

Medical Staff Members and Privilege holders shall be entitled to a Fair Hearing, and to be advised as to what Adverse Actions trigger the Fair Hearing Process, all of which are more fully described in the Fair Hearing Plan. The following actions, when recommended by the MEC or the Board, are deemed to be Adverse, only when pertaining to the professional competence or conduct of a Member or Privilege holder:

- Denial of Medical Staff Membership
- Denial of reappointment as a Member of the Medical Staff
- Involuntary Reduction or involuntary change in Medical Staff category status
- Suspension of Medical Staff Membership
- Revocation of Medical Staff Membership
- Denial of requested Clinical Privileges, excluding Temporary Privileges (unless such denial of Temporary Privileges acts as a denial of an application for Membership)
- Reduction of Clinical Privileges for a period longer than fourteen (14) days
- Suspension of Clinical Privileges for a period longer than fourteen (14) days
- Revocation of all Clinical Privileges
- Restriction of Clinical Privileges by requiring that a Practitioner obtain special consultation or permission to perform certain procedures, excluding probation or monitoring incidental to newly granted Privileges
- Special limitation of the right to admit patients not related to standard administrative or Medical Staff policies
- Individual application of, or individual changes in, mandatory consultation requirements
- Denial of requested Departmental affiliation
- Restriction of requested Clinical Privileges
- Denial of requested appointment to or advancement in Staff Category

### 11.2 NOTICE OF ADVERSE ACTION

Medical Staff Members and Practitioners shall have the right to receive notice of Adverse Action and of their right to request a Fair Hearing, such notice to be delivered in a timely manner. Medical Staff Members and Practitioners shall have thirty (30) calendar days following the date of receipt of notice of Adverse Action within which to request a Hearing. A Member or Practitioner who fails to request a Hearing within this time period and in the manner specified in the notice waives all rights to any Hearing or appellate review.

### 11.3 HEARING PANEL

When a Hearing is requested, a Hearing panel of at least three (3) Medical Staff Members, none of whom shall be in direct economic competition with the affected Member or Practitioner, will be appointed by the Hospital President upon recommendation of the Medical Staff President. No individual appointee to the Hearing panel shall have actively participated in any consideration of the matter at any previous level. However, mere knowledge of the matter shall not preclude any individual from serving as a member of the Hearing panel.

## ARTICLE TWELVE: CONFIDENTIALITY, IMMUNITY AND RELEASES

### 12.1 AUTHORIZATIONS AND CONDITIONS

By submitting an application for Staff Membership or by applying for or exercising Clinical Privileges or providing patient care services at the Hospital, the applicant, Member, or Practitioner:

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- A. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon Information concerning individual professional ability and qualifications.
- B. Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative who acts in accordance with the provisions of this Article.
- C. Acknowledges that the provisions of this Article are conditions of application for, and acceptance of, Staff Membership and of the continuation of such Membership and are also conditions of application for, acceptance of, and the exercise of Clinical Privileges and of the maintenance of such Clinical Privileges.

## **12.2 CONFIDENTIALITY OF INFORMATION**

Any oral or written Information submitted, collected, or prepared by any Representative of this Medical Staff or any Representative of this or any other health care facility, organization, or medical staff for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, determining that health care services are professionally indicated or were performed in compliance with the applicable standard of care, or establishing and enforcing guidelines to keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Representative, and shall not be used in any way except as provided herein except as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by third parties. All activities of the Medical Staff, the Board, and any Committees or Departments of either will be governed by the Indiana Peer Review Act and the federal Health Care Quality Improvement Act when such activities relate to peer review matters.

## **12.3 IMMUNITY FROM LIABILITY**

### **12.3-1 FOR ACTION TAKEN**

No Representative of the Hospital or Medical Staff shall be liable to an applicant, Member, or Practitioner for damage or other relief for any decision, opinion, action, statement, or recommendation made within their scope of duties as a Representative, if such Representative acts in good faith and without malice within the scope of this function and has made a reasonable effort to obtain the facts of the matter and acts in the reasonable belief that the action is warranted by such facts.

### **12.3-2 FOR PROVIDING INFORMATION**

No Representative of the Hospital or Medical Staff and no third party shall be liable to an applicant, Member, or Practitioner for damages or other relief by reason of providing Information, including otherwise privileged or confidential Information, to a Representative of this Hospital or Medical Staff or to any other health care facility or organization of health professionals concerning an individual who is or has been an applicant to or Member of the Staff or who has been an applicant for or who did or does hold or exercise Clinical Privileges or provide specified services at this Hospital, provided that such Representative or third party acts in good faith and without malice within the scope of this function and has made a reasonable effort to obtain the facts of the matter concerning this Information and provided further that such Information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

## **12.4 ACTIVITIES AND INFORMATION COVERED**

### **12.4-1 ACTIVITIES**

The confidentiality and immunity provided by this Article applies to all Information or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- Applications for Membership, Clinical Privileges or specified services,
- Periodic reappraisals for Membership reappointment, Clinical Privileges or specified services,
- Corrective Action or disciplinary action,



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- Hearings and appellate reviews,
- Quality Assessment program activities,
- Utilization reviews,
- Claims reviews,
- Profiles and profile analysis,
- Malpractice loss prevention, and
- Other Hospital, Committee, Department, or Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

## **12.4-2 INFORMATION**

The Information referred to in this Article may relate to an applicant's, Member's or Practitioner's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect the quality or efficiency of patient care provided at the Hospital.

## **12.5 RELEASES**

Each applicant, Member, and Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under relevant Indiana laws. Execution of such releases is not a prerequisite to the effectiveness of this Article.

## **12.6 CUMULATIVE EFFECT**

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of Information, and immunity from liability are in addition to other protections provided by relevant Indiana laws and are not in limitation thereof.

## **12.7 MEDICAL MALPRACTICE PAYMENTS**

The Hospital will report to the National Practitioner Data Bank and to the Medical Licensing Board any payments it makes for the benefit of a licensed health care provider in accordance with regulations governing such obligations.

## **ARTICLE THIRTEEN: GENERAL PROVISIONS**

### **13.1 STAFF DUES**

The MEC will establish the amount of Medical Staff dues for Members and Privilege holders. Dues are payable at the time of reappointment/recredentialing. Failure to render payment, unless excused by the MEC for good cause, shall, after Special Notice of the delinquency, result in Automatic Suspension of Staff Membership and Clinical Privileges until the delinquency is remedied. If dues remain unpaid for a reasonable period after a second Special Notice has been issued, the Member or Practitioner will be deemed to have voluntarily resigned from the Medical Staff and to have voluntarily relinquished any Clinical Privileges.

### **13.2 CONSTRUCTION OF TERMS AND HEADINGS**

Words used in these Bylaws will be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

## **ARTICLE FOURTEEN: ADOPTION AND AMENDMENT**

### **14.1 MEDICAL STAFF RESPONSIBILITY**

The Board has delegated to the Organized Medical Staff the responsibility to develop, review, and recommend Medical Staff Bylaws, procedures, plans, policies, and amendments as needed, and such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these Bylaws. Documents so developed will be effective upon approval by the Board. Neither the Organized Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws. The Organized Medical Staff shall not delegate the right to adopt and amend the Bylaws.

# MEDICAL STAFF BYLAWS / MEMORIAL HOSPITAL OF SOUTH BEND, INC

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## **14.2 METHOD OF ADOPTING AND AMENDING THE MEDICAL STAFF BYLAWS**

The Medical Staff Bylaws will consist solely of this document entitled Medical Staff Bylaws. All proposed amendments to the Bylaws must originate with the MEC or by a petition signed by ten (10%) percent of the Active Medical Staff Members.

Each Active category Medical Staff Member will be eligible to vote on the proposed amendment to the Medical Staff Bylaws via printed or secure electronic ballot in a manner determined by the MEC. In order to be adopted, such proposed amendment must receive a simple majority affirmative vote with submission of a vote by at least 20% of the Organized Medical Staff constituting a quorum.

Bylaws and amendments so adopted shall become effective when approved by the Board.

## **14.3 METHODS OF ADOPTING AND AMENDING THE MEDICAL STAFF RULES AND REGULATIONS, AND RELATED MANUALS**

The MEC will recommend to the Board a Credentialing Procedures Manual, an Organizational Manual, a Fair Hearing Plan, Medical Staff Rules and Regulations, and a Policy Manual that further define the general principles contained in these Medical Staff Bylaws. This responsibility is delegated to the MEC by the Organized Medical Staff.

All proposed amendments to the Credentialing Procedures Manual, the Organizational Manual, the Rules and Regulations, the Fair Hearing Plan and the Policy Manual, whether originating with the MEC, another standing Committee, or by petition signed by 10% of the Active Medical Staff Members, will be reviewed by the MEC prior to a MEC vote on recommendation to the Hospital Board. The Organized Medical Staff will be advised of Rules or Regulations or proposed amendments of the Rules or Regulations before these come to a vote before the MEC. The Organized Medical Staff will be advised of MEC action on Policies and amendments to Policies. Such notification shall be by way of posting MEC summary reports on the Hospital web site. Disagreement between the MEC and a contingent of 10% of the Organized Medical Staff concerning advance of any proposal to the Board will invoke formation of a Conference Committee consisting of three members chosen by the MEC and three members chosen by the Organized Medical Staff which will attempt to develop a proposal acceptable to both groups. Irrespective of any of these efforts, a petition signed by one-third of the Organized Medical Staff will advance a proposal to the Board without MEC approval, such proposal to be accompanied by the MEC dissenting opinion and a proposal originating with the MEC will advance to the Board despite opposition by a 10% contingent of the Organized Medical Staff, such proposal to be accompanied by the 10% contingent's dissenting opinion. The Board shall have final authority to resolve any such conflicts.

The MEC will review the Credentialing Procedures Manual, the Organizational Manual, and the Rules and Regulations and Policy Manuals at least every five years.

Manuals and Rules and Regulations and amendments that are recommended to the Board through the processes in this section shall be effective only when approved by the Board; the MEC may correct typographical, spelling, or other obvious errors in these documents without Board approval. The Related Manuals and the Rules and Regulations of the Medical Staff shall have the same force and effect as the Bylaws; however in cases of discordance, the Bylaws shall prevail. In the case of discordance among or between any of the Staff governance documents, each document will prevail in the following order: 1 Bylaws, 2 Fair Hearing Plan, 3 Organizational Manual, 4 Credentialing Manual, 5 Rules and Regulations, 6 Policy Manual.

## **14.4 URGENT MEDICAL STAFF ACTION**

If following the routine procedure for amending the Medical Staff Bylaws would be contrary to the best interests of the Medical Staff, the Medical Staff President may, with the concurrence of a majority of the members of the MEC and with concurrence of the Bylaws Committee, call a Special Meeting of the Organized Medical Staff to vote on a proposed amendment to the Medical Staff Bylaws.

Active category Medical Staff Members will be given at least ten (10) days notice of the meeting, unless the urgency of the situation demands more rapid action.

Under this process, a majority vote of those present, eligible to vote and voting is required to adopt an amendment to the Bylaws and to recommend it to the Board for approval.

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When in the opinion of the MEC or the Board, urgent action is required in order to comply with law or regulation, the MEC may provisionally adopt Rules and Regulations or amendments thereto and recommend these to the Board for provisional approval. After approval, the Organized Medical Staff will be notified and if there is no objection, the action stands. A petition by 10% of the Active Medical Staff Members within 30 days of the date of notification will be treated as an objection and will be invoke formation of a Conference Committee consisting of three members chosen by the MEC and three members chosen by the Organized Medical Staff which will attempt to develop a proposal acceptable to both groups. Failure of the Conference Committee, within 45 days of its formation, to make a recommendation, or failure of the MEC to approve such recommendation, or failure of the recommendation to be acceptable to the Organized Medical Staff shall be considered to be failure of the conflict resolution process. Irrespective of any of these efforts, a petition signed by one-third of the Active Medical Staff Members will advance a proposal to the Board without MEC approval, such proposal to be accompanied by the MEC dissenting opinion. The Board shall have final authority to resolve any conflicts concerning Urgent Medical Staff Action.

## **14.5 BOARD ACTION/CONFLICT RESOLUTION**

Medical Staff recommendations are approved upon the affirmative vote of a majority of the Board of Trustees. The date a recommendation becomes effective is the date of Board approval or such later date as the Board may specify. The Board of Trustees upholds any Medical Staff Bylaws, Related Manuals, Rules and Regulations, and Policies that it has approved.

In the event the Board of Trustees acts in a manner contrary to a recommendation by the MEC, the matter may (at the request of the MEC) be submitted to a joint conference committee composed of the Officers of the Medical Staff and an equal number of members of the Board for review and recommendation to the full Board. The Committee will submit its recommendation to the Board of Trustees within thirty (30) days of its meeting. An analogous mechanism may be used for conflict resolution between the Board and a contingent of at least 10% of the Active Staff Members who present their issue by petition to the Board.

The Chair of the Board of Trustees or the Medical Staff President may call for a joint conference as described above at any time and for any reason in order to seek direct input from Medical Staff leaders, clarify any issue, or relay information directly to Medical Staff leaders.

## **14.6 MEDICAL STAFF/MEC CONFLICT RESOLUTION**

A disagreement between the MEC and the Organized Medical Staff will be documented by petition addressing the contested issue(s) signed by at least 10% of the Active Staff Members and presented to the Medical Staff President. Presentation of such a petition will invoke formation, within 15 days, of a Conference Committee consisting of three members chosen by the MEC and three members chosen by the Organized Medical Staff which will attempt to develop a proposal acceptable to both groups. Failure of the Conference Committee, within 45 days of its formation, to make a recommendation, or failure of the MEC to approve such recommendation, or failure of the recommendation to be acceptable to the Organized Medical Staff shall be considered to be failure of the conflict resolution process. Irrespective of any of these efforts, a petition signed by one-third of the Active Medical Staff Members will advance a proposal to the Board without MEC approval, such proposal to be accompanied by the MEC dissenting opinion. The Board shall have final authority to resolve any disagreements between the MEC and the Organized Medical Staff.

## **14.7 INTERPRETATION**

Whenever the Medical Staff governance documents do not specifically address a topic or do not adequately cover a matter, or there is a need for interpretation, The MEC may issue an interpretation. In arriving at an interpretation, the MEC may take into account the usual and customary policies and practices of the Medical Staff, whether written or otherwise, and in its discretion may also bring to bear the expert medical knowledge of its members, and may also take into account testimony and opinion from others who have expertise in the issues at hand.

In that most members of the MEC are not attorneys, these Bylaws are to be interpreted as permitting reasonable leeway in all proceedings and in the interpretation of the Medical Staff governance documents, but there should always be strong effort to substantially comply with the provisions of the governance documents. In the event of a substantial deviation, the reason for such deviation should be documented.

***CERTIFICATION OF ADOPTION AND APPROVAL***

***Adopted by the Medical Staff  
February 4, 2011***

***Approved by the Board of Trustees  
February 24, 2011***

# MEDICAL STAFF BYLAWS / MEMORIAL HOSPITAL OF SOUTH BEND, INC

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## DEFINITION OF TERMS

1. **Allied Health Professional** or **AHP** means duly licensed or credentialed individuals who are qualified to practice in a medical role within the Hospital under the direction of a Licensed Independent Practitioner who is a Medical Staff Privilege Holder. AHPs include Advanced Practice Professionals (APPs), i.e., nurse practitioners, clinical nurse specialists, certified nurse midwives, and physician assistants, as well as licensed or non-licensed individuals who do not provide a medical level of care and who are directly supervised by a Licensed Independent Practitioner who is a Medical Staff Privilege Holder; e.g, dental assistants, registered nurses, surgical assistants, etc.
2. **Board of Trustees** or **Hospital Board** or **Board** means the Governing Body of the Hospital which is the Board of Trustees of Memorial Hospital of South Bend, Inc.
3. **Clinical Privileges** or **Privileges** means the permission that is granted to provide those diagnostic, therapeutic, medical, or surgical services specifically delineated to each Practitioner.
4. **Ex Officio** means service as a member of a body by virtue of office or position held and, unless otherwise expressly provided, means without voting rights.
5. **Good Standing** means a status of Medical Staff Membership without any current Privilege or Membership restrictions.
6. **Hospital** means Memorial Hospital of South Bend, Inc., South Bend, Indiana
7. **Hospital President** or **President** means the individual appointed by the Board as the Chief Executive Officer to act on its behalf in the overall administrative management of the Hospital.
8. **Information** means records of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data, and other disclosures or communications, whether in written or oral form, relating to any of the subject matter specified in these Bylaws
9. **Licensed Independent Practitioner** means any Practitioner permitted by law and by the Medical Staff and the Hospital to provide patient care and services at the Hospital, without direction or supervision, within the scope of the Practitioner's license and individually granted Privileges.
10. **Medical Staff** or **Staff** means the formal organization of all Practitioners who are Members of this organization and/or are privileged to attend patients or to provide other diagnostic, therapeutic, teaching or research services at the Hospital. The **Organized Medical Staff** means that group of Medical Staff Members who have the right to vote in adoption and amendment of the Bylaws.
11. **Medical Staff Bylaws** or **Bylaws** means the document entitled Medical Staff Bylaws. The **Related Manuals** are entitled Medical Staff Organizational Manual, Credentialing Procedures Manual and the Medical Staff Fair Hearing Plan.
12. **Membership** or **Staff Membership** means association with the Medical Staff in one of the Medical Staff categories with assumption of the associated Membership Rights and Responsibilities. A **Member** or **Staff Member** is an individual who has attained Membership.
13. **Practitioner** means, unless otherwise expressly provided, any physician (M.D. or D.O.), podiatrist, or dentist applying for or exercising Clinical Privileges or providing diagnostic, therapeutic, teaching, or research services at the Hospital. This term does not include AHPs.
14. **Representative** means a board of a hospital or any director or committee thereof; a hospital chief executive officer or designee; registered nurse and other hospital employee of a hospital; a medical staff organization and any member, officer, clinical unit or committee thereof; or any individual authorized by any of the foregoing to perform specific Information gathering, analysis, use, or disseminating functions.
15. **Special Notice** means written notification sent by certified or registered mail, return receipt requested. Notice shall be deemed given as of the date of mailing.
16. **Telemedicine** means the provision of clinical services or diagnosis and treatment of patients by Practitioners from a distance by means of communication technologies. The Distant Site is the site at which the Telemedicine Practitioner is physically located, while the Originating Site is the site where the clinical services are being provided or where the patient is receiving care.