



BYLAWS OF THE MEDICAL STAFF

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	Page #:
Preamble	2
Definitions	3
1. Purpose	5
2. Categories of the Medical Staff	6
2.1.1 Active Staff	6
2.1.2 Courtesy Staff	7
2.1.3 Affiliate Staff	7
2.1.4 Honorary Staff	8
3. Organization of the Medical Staff	8
3.1 Unification with other Medical Staff(s)	8
3.2 Disunification with other Medical Staff(s)	9
3.3 Unification/Disunification Effect on Bylaws	9
3.4 Medical Staff Year	9
3.5 Officers of the Medical Staff	9
3.6 Meeting of the Active Medical Staff Membership	11
3.7 Department and Committee Meetings	12
3.8 Provisions Common to all Meetings	13
3.9 Rules of Order	14
4. Departments of the Medical Staff	14
4.1 List of Departments	14
4.2 Functions of Departments	14
4.3 Department Chairman	15
4.4 Function of Department Chairman	15
5. Committees of the Medical Staff	16
5.1 Appointment	16
5.2 Optional Groups	16
5.3 Medical Executive Committee	17
5.4 Credentials Committee	18
5.5 Medical Staff Quality Improvement Committee	19
5.6 Meetings, Reports and Recommendations	20
5.7 Special Committees	20
5.8 Standing "Other" Committees	20
6. Appointment	20
6.1 Qualifications for Appointment to the Medical Staff	20
6.2 Conditions of Appointment	22
6.3 Application for Initial Appointment and Clinical Privileges	24
6.4 Procedure for Initial Appointment	26

7.	Clinical Privileges	29
7.1	Clinical Privileges Delineated	29
7.2	Non-Reportable Actions	30
7.3	Telemedicine Clinical Privileges	30
7.4	Temporary Clinical Privileges	32
7.5	Disaster Clinical Privileges	34
7.6	Outpatient Diagnostic Services	36
7.7	Medico-Administrative Privileges	36
7.8	Special Conditions for Residents and Fellows	36
7.9	Option to Expedite	37
8.	Actions Affecting Medical Staff Members	38
8.1	Procedure for Reappointment	38
8.2	Procedures for Requesting Increase in Clinical Privileges	43
8.3	Performance Improvement and Quality of Care Review	43
8.4	Procedure for Leave of Absence	47
8.5	Fair Hearing Plan	48
9.	Hearing and Appellate Review Procedure	48
10.	Rules and Regulations of the Medical Staff	48
11.	Immunity from Liability	49
12.	Allied Health Providers and Physician Extenders	50
12.1	Allied Health Care Providers	50
12.2	Physician Extenders	53
12.3	Corrective Action	56
13.	History and Physical Requirements	57
14.	Related Medical Staff Documents	57
14.1	Adoption of Related Documents	57
14.2	Medical Staff Bylaws are not a Contract	57
14.3	Rules and Regulations	57
14.4	Medical Staff Policies	58
15.	Conflict Resolution	58
16.	Amendments and Periodic Review	59
17.	Dues and Fees	60
18.	Adoption	60

PREAMBLE

WHEREAS, Elkhart General Hospital is a non-profit corporation organized under the laws of the State of Indiana with the purpose of providing patient care, education and research; and

WHEREAS, the Hospital Board wishes to delegate to a single organized Medical Staff duties and responsibilities for monitoring the quality of medical care in the Hospital and reporting thereon to the Board and wishes to delegate the authority and responsibility to make recommendations to the Board concerning an applicant's appointment or reappointment to the Medical Staff of the Hospital and the clinical privileges such applicant shall enjoy in the Hospital.

THEREFORE, to discharge these duties and responsibilities and to establish a framework for Medical Staff activities and accountability to the Board, the Medical Staff of Elkhart General Hospital shall function and act in accordance with the following Bylaws and procedures, subject to the approval of the

Board. The Hospital management shall cooperate with and assist the members of the Medical Staff in the accomplishment of this responsibility to the Hospital.

DEFINITIONS

The following definitions apply to these Medical Staff Bylaws and its related manuals. The use of capitalization when defining terms is intended for convenience purposes only and shall not affect the meaning or interpretation of such terms throughout these Bylaws.

ADMITTING PHYSICIAN means the physician who performs the admitting history and physical exam.

ADVANCED PRACTICE NURSE means a Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), or Certified Nurse Midwife (CNM).

ATTENDING PHYSICIAN means the physician who is responsible for coordinating the care of the patient during the hospitalization-and coordinating the follow-up care.

ALLIED HEALTH PROFESSIONAL or **AHP** means any individually licensed or certified health care provider who is not a physician or oral maxillofacial surgeon, who has an independent or dependent scope of practice, and who may qualify to exercise specified clinical privileges within the Hospital. An AHP may include a dentist (excepting those dentists with advance degrees in oral maxillofacial surgery), podiatrist, psychologist, certified registered nurse anesthetist, physician's assistant, nurse practitioner, or midwife, who is licensed or certified by the State of Indiana, and who meets the standards and criteria for qualifications, duties, responsibilities, and privileges by the Medical Staff and approved by the Board. Upon the granting of clinical privileges, AHPs are not Members of the Medical Staff, this includes Dentists and Podiatrists. The procedural rights afforded to AHPs who have been granted Clinical Privileges are set forth in Article XVII of these Bylaws.

APPLICANT means any individually licensed or certified health care provider, including Physicians, Dentists, Podiatrists, and AHPs, who is applying for Membership or reappointment on the Medical Staff, Clinical Privileges, or permission to provide health care services as appropriate at the Hospital.

BOARD or **BOARD OF DIRECTORS** shall mean the Board of Directors of Elkhart General Hospital, which has the overall responsibility for the conduct and operations of the Hospital.

CHIEF OF STAFF means the individual duly elected by the Medical Staff to serve as the primary elected Medical Staff officer holding the responsibilities and obligations of Medical Staff Representative, Medical Staff Chief Administrative Officer, and Medical Staff Chief Clinical Officer.

CLINICAL PRIVILEGES mean Board-granted privileges and/or other circumstances pertaining to the furnishing of medical or other patient care under which a Practitioner is permitted to provide medical or other patient care services to patients at the Hospital and to utilize Hospital resources that are necessary to provide such medical or other patient care services.

CONSULTING PHYSICIAN means the recognized medical specialist who provides consultation in the diagnosis and treatment for Hospital patients.

DENTISTS mean individuals who are licensed to practice dentistry in the State of Indiana, who are subject to the Health Care Quality Improvement Act of 1986.

EX-OFFICIO means membership of a committee or board by virtue of an office or position held within the organization. An ex-officio member cannot be counted in the number to determine establishment of a

quorum. An ex-officio member has the right to participate in the committee proceedings, make motions and vote but has no obligation to do so.

GOOD STANDING means being under no form of suspension, probation, or restriction of any kind regarding Medical Staff appointment or clinical privileges at the Hospital and/or at any other health care facility or organization.

HOSPITAL means the Elkhart General Hospital, Inc.

HOSPITAL ADMINISTRATION means the executive administrative leadership of the Hospital consisting of the President, Chief Financial Officer Vice President of Medical Staff Affairs and Vice President of Nursing their respective administrative staff.

HOSPITAL BYLAWS shall refer to the Governing Bylaws of the Elkhart General Hospital, Inc.

MEDICAL EXECUTIVE COMMITTEE or MEC means the Medical Staff Executive Committee.

MEDICAL STAFF or STAFF means all Physicians, who are duly appointed by the Board as Members of the Medical Staff.

MEDICAL STAFF BYLAWS or BYLAWS shall refer to the Medical Staff Bylaws and related manuals of Elkhart General Hospital, Inc., as duly approved by its Medical Staff and Board, and as more fully described in such documents.

MEMBER means any Physician or Oral Maxillofacial Surgeon who has been duly appointed by the Board as a Member of the Medical Staff.

MEMBERSHIP means to have the duly appointed status of being a Member of the Medical Staff of Elkhart General Hospital, Inc.

NOTICE or SPECIAL NOTICE means written notification sent by certified or registered mail, return receipt requested and/or personally delivered by hand. All requests, statements and other communications made by Special Notice shall be copied to the Chief of Staff and the President.

NUMBER OF DAYS or DAYS means "calendar days" (i.e. including Saturday, Sunday, and legal holidays) unless the due date falls on a Saturday, Sunday or legal holiday, in which event the due date shall be the first day immediately following which is not a Saturday, Sunday, or legal holiday.

PATIENT CONTACTS means, unless otherwise specified herein, an inpatient admission, consultation, inpatient or outpatient surgical procedure, inpatient or outpatient observation of patients. A "patient contact" shall include those activities commensurate with the scope of clinical privileges held by the member for those patient contacts that do not involve practitioner-to-patient encounters, including pathology and radiology-related contacts. Upon member request and presentation of sufficient information, the Medical Executive Committee reserves the right in its sole discretion to establish certain patient care activities not listed above as meeting the patient contact requirement.

PEER REVIEW COMMITTEE or PROFESSIONAL REVIEW BODY means the Board, the MEC, the Medical Staff Quality Improvement Committee, any committee of the Medical Staff or Board, or their designated personnel and agents having the responsibility for evaluation, recommendation or making a determination concerning qualifications of a professional health care provider, patient care rendered by a professional health care provider, or the merits of a complaint against a professional health care provider. Peer Review Committee or Professional Review Body functions shall include the review of competence and professional conduct of professional health care providers leading to determinations concerning the granting

of clinical privileges or Medical Staff Membership, the scope and condition of such clinical privileges or Membership, and the modification of such clinical privileges or Membership.

PERFORMANCE IMPROVEMENT refers to activities related to the continuous improvement of care and the assurance of quality of care in the Hospital and its related activities, and includes such activities when referred to by other terms, such as, but not limited to, quality assurance, quality assessment, continuous quality improvement, and total value management;

PHYSICIAN means doctors of medicine and osteopathy who are licensed to practice medicine in the State of Indiana, who are subject to the Federal Health Care Quality Improvement Act of 1986, and who are Members of, or Applicants to, the Medical Staff.

PHYSICIAN EXTENDER shall mean a person either holding a limited license or technical training in a specific specialty and employed by an admitting physician and who does not qualify for independent privileges, such as a physician-employed nurse, dental assistant, cast technician, physician-employed operating room technician, certified surgical technician, certified first assistant, perfusionist, and perfusion assistant, and other physician-employed persons. Physician Extenders work under the direct supervision of the physician employer or physician sponsor at all times. Physician Extenders shall not be considered Allied Health Care Providers under these Bylaws.

PODIATRISTS mean individuals who are licensed to practice podiatry in the State of Indiana.

PRACTITIONER means any member of the Medical Staff or AHP, who meets the standards and criteria for qualifications, duties, responsibilities, and privileges by the Medical Staff and approved by the Board of Directors.

PRESIDENT means the individual appointed by the Board to act in its behalf as President of the Hospital with the delegated responsibility of overall management of the Hospital and its operations.

RELATED MANUALS means those manuals that are a part of these Medical Staff Bylaws and include the Fair Hearing Plan and the Medical Staff Rules and Regulations.

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

1. **PURPOSE.** The overall goal of the Hospital is to provide quality patient care. The Board and the Medical Staff and its members are committed in working together to pursue this common goal. In pursuing this goal, the Medical Staff acts as an extension of the Hospital and its Board in assisting them to carry out their legal responsibility to provide quality patient care. In acting through its duly appointed and functioning departments and committees in accordance with these Bylaws and subject always to the ultimate authority of the Board, the Medical Staff shall discharge the duties and responsibilities delegated to it by the Board as an agent for the Board, including but not limited to the following:

1.1 By and through its Peer Review organizations to monitor the quality of medical care in the Hospital and to make recommendations thereon to the Board so that all patients admitted to or treated at any of the facilities, departments or services of the Hospital shall receive appropriate care.

1.2 By and through its Peer Review organizations to make recommendations to the Board concerning the appointment or reappointment of an applicant to the Medical Staff of the

Hospital; to recommend to the Board the clinical privileges such applicant shall have in the Hospital and to review and evaluate such clinical privileges on a continuing basis once given; and to recommend to the Board any appropriate action that may be necessary in connection with any member of the Medical Staff.

- 1.3 To establish procedures whereby issues concerning the Medical Staff and the Hospital may be discussed both within the Medical Staff and with the Board and the management of the Hospital.
 - 1.4 To establish specific rules and regulations to govern actions and professional responsibilities of members of the Medical Staff.
 - 1.5 To provide an appropriate educational setting that will maintain scientific standards, lead to advancement in professional knowledge and skill, and encourage and support clinical and basic research.
 - 1.6 To cooperate with universities and other institutions, where appropriate, in undergraduate, graduate and postgraduate education.
 - 1.7 These Bylaws, which originate with the Medical Staff, are adopted in order to provide for the organization of the Medical Staff of Elkhart General Hospital and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors of Elkhart General Hospital and relations with applicants to and members of the Medical Staff. These Bylaws, when accepted by the Board of Directors, create a system of mutual rights and responsibilities between members of the Medical Staff and the Hospital.
2. **CATEGORIES OF THE MEDICAL STAFF.** All appointments to the Medical Staff shall be made by the Board and shall be to one of the following categories of the staff:
- 2.1 Physicians participating in the EGH Hospitalist program are required to maintain Active or Courtesy Staff status. Additionally, members of the Medical Staff in the Active and Courtesy categories are required to participate in Emergency Department call for outpatient follow up, inpatient care, or both depending on the approved privileges of the individual physician and department specific rules and regulations. A Medical Staff Member will be exempt from ED call after age 60 if he/she has had 10 years of service at EGH or Beacon Health System unless he/she indicates, in writing, that continued ED call is desired. Medical Staff Members are required to notify the Chief of Staff of their intent to continue call for the next twelve months annually, in writing, after age 60. The Medical Staff Services Department will facilitate this communication with appropriate documents and notifications.
 - 2.1.1 **ACTIVE STAFF.** The Active Medical Staff shall consist of physicians and oral surgeons with an unlimited license to practice medicine or oral maxillofacial surgery in Indiana who wish to be associated with the Hospital and its Medical Staff and desire to have their patients receive medical care and services at Elkhart General Hospital. Members of the Active Medical Staff shall be appointed to an appropriate department(s), shall be eligible to vote, to hold office and to serve on Medical Staff committees, and shall be required to attend Medical Staff meetings as specified in these Bylaws.

2.1.2 COURTESY STAFF. Members in this category shall consist of physicians oral surgeons with an unlimited license to practice medicine or oral maxillofacial surgery in Indiana who wish to be associated with the Hospital and the Medical Staff. Staff members in this category shall be physicians and oral surgeons of demonstrated competence qualified for staff membership who do not utilize Elkhart General Hospital as their primary facility, are located in the same geographical proximity to the Hospital as Active staff, and can demonstrate that they are on the Active staff of a licensed hospital within the Hospital's service area. The primary hospital must require participation in quality management activities consistent with those of this Hospital. Courtesy Medical Staff shall assume all the functions and responsibilities of membership on the Medical Staff including, where appropriate, emergency service care and consultation assignments, and an obligation to complete all necessary medical records of their patients. However, Courtesy Medical Staff Members will have no staff committee responsibilities, may not vote, and may not hold office. Members of the Courtesy Staff category are encouraged to attend staff and department meetings. Medical Staff who admit or attend to more than fifty (50) patients in two years may trigger review by the MEC for recommendation to a more appropriate staff category. Medical Staff recommended for change to another category as a result of this review, may request an exception by the MEC.

2.1.3 AFFILIATE STAFF. Members in this category shall consist of the following physicians and oral surgeons who maintain an unlimited license to practice medicine or oral maxillofacial surgery in Indiana, and who demonstrate the competence required for membership and clinical privileges required by these Bylaws:

- 2.1.3.1** Physicians and oral surgeons who intend to exclusively exercise clinical privileges remotely via telemedicine link;
- 2.1.3.2** Physicians and oral surgeons who are faculty visiting from other institutions for the exclusive purpose of conducting medical education or research, and who assume those responsibilities required of their medical education, research, or training program (as applicable);
- 2.1.3.3** Physicians and oral surgeons on the Active Staff of another Medicare participating hospital who intend to exclusively serve as visiting proctors (as requested/invited by the Hospital), and who therefore conduct and document concurrent reviews for physicians, oral surgeons, and/or AHPs at the Hospital (as applicable);
- 2.1.3.4** Physicians and oral surgeons who intend to exercise clinical privileges either in a temporary capacity (for a period greater than that permitted by these Bylaws for temporary clinical privileges, but less than two (2) years, or otherwise intend to serve exclusively for the purpose of providing coverage for another member(s) of the Active or Courtesy Staff, and

2.1.3.5 Any other physician or oral surgeon that does not otherwise qualify for placement in the Active or Courtesy Staff, and in the discretion of the MEC, should be placed in the Affiliate Staff.

Members of the Affiliate Staff shall satisfy all obligations and functions of the Medical Staff, unless expressly made exempt by the MEC, and shall exercise only those clinical privileges that are granted by the Board. Members of the Affiliate Staff may attend Medical Staff and Department meetings, but are not eligible to serve on Medical Staff Committees, vote, or hold elected office in the Medical Staff.

2.1.4 HONORARY STAFF. The Honorary Medical Staff shall consist of physicians and selected individuals who have made outstanding contributions to Elkhart General Hospital. Honorary Staff members shall not be eligible to attend, admit or consult on patients, to vote, to hold office or to serve on standing Medical Staff committees, but may be appointed to special committees.

3. ORGANIZATION OF THE MEDICAL STAFF

3.1 UNIFICATION WITH OTHER MEDICAL STAFF(S): The Medical Staff of Elkhart General Hospital can be included in a unified medical staff of any health system in which the Hospital participates only after:

3.1.1 There has been six (6) months' prior written notice to all Active Medical Staff Members and Courtesy Medical Staff members with Active Privileges describing the proposed unification, setting forth its risks, benefits, and effects to the Medical Staff and its members;

3.1.2 The Medical Executive Committee concurs with considering unification (based on a 2/3 majority vote of Medical Executive Committee voting members) following review and study;

3.1.3 No less than two-thirds of all Medical Staff Members with voting rights who also hold active clinical privileges to practice on-site at the hospital cast votes in favor of unification.

3.1.3.1 The Medical Executive Committee shall determine whether the medical staff votes (CMS State Operations Manual, Appendix A- Only those individuals who hold privileges to practice at the hospital and actually do practice on-site, and not just via telemedicine are permitted to vote on unification/disunification.): At a special meeting called for that purpose following meeting notice of at least thirty (30) days, or Via mail or electronic balloting which demonstrates the identity of the voter so as to confirm voting rights as outlined above.

3.1.4 If all of these requirements are not met, the Medical Staff shall remain separate from any System-Unified hospital and continues as the medical Staff of Elkhart General Hospital.

- 3.1.5** If the Medical Staff votes to accept unification, these Medical Staff Bylaws will remain in effect as to the Members, until the Medical Staff Bylaws are amended or new Medical Staff Bylaws are adopted pursuant to the terms of these Bylaws.

When contemplating amendment or adoption of new Bylaws:

- 3.1.5.1** The unified and integrated medical staff takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital.
- 3.1.5.2** The unified and integrated medical staff establishes and implements policies and procedures to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, regardless of practice or location, are given due consideration.
- 3.1.5.3** The unified and integrated medical staff has mechanisms in place to make certain that issues localized to particular hospitals within the system are duly considered and addressed.

- 3.2 DISUNIFICATION FROM OTHER MEDICAL STAFFS:** The Medical Staff shall disunify from any system-unified medical staff by vote to disunify by two-thirds of all Medical Staff Members with voting rights who hold clinical privileges to practice on-site at the hospital. The Medical Staff shall be the unique Medical Staff of the Hospital effective immediately, operating under the Medical Staff Bylaws in effect immediately prior to unification. Special election shall be called to elect officers, department chairs and other medical staff leadership immediately consistent with the Medical Staff Bylaws in effect immediately prior to unification.
- 3.3 UNIFICATION/DISUNIFICATION EFFECT ON BYLAWS:** A vote by the Medical Staff to accept a unified medical staff shall have no effect on the application of these Medical Staff Bylaws, which shall continue to govern this Medical Staff and be upheld by the Governing Body. Peer review and other activities of the Medical Staff and its Members shall continue to be governed by Indiana law by which the Hospital is licensed. Upon disunification, the Medical Staff Bylaws in effect the date of unification shall return to full force and effect.
- 3.4 GENERAL: MEDICAL STAFF YEAR.** For the purpose of these Bylaws, the Medical Staff year commences on the first day of January and ends on the thirty-first day of December each year.
- 3.5 OFFICERS OF THE MEDICAL STAFF.** The officers of the Medical Staff of the Elkhart General Hospital shall be the Chief of Staff, Vice-Chief of Staff, Past Chief, and Secretary-Treasurer. Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.
- 3.5.1 Duties of the Chief of Staff**
- 3.5.1.1** Presides at all meetings of the Medical Staff.
- 3.5.1.2** Chairs the MEC.

- 3.5.1.3 Has such other powers, duties and responsibilities as shall be conferred on him/her by these Bylaws.
- 3.5.1.4 Represents the staff in its relations with the Board and Hospital management.
- 3.5.2 **Duties of the Vice-Chief of Staff**
 - 3.5.2.1 Assumes all duties and has the authority of the Chief of Staff in his or her absence.
 - 3.5.2.2 Is a member of the MEC of the Medical Staff.
 - 3.5.2.3 Automatically succeeds the Chief of Staff when the latter fails to serve for any reason.
- 3.5.3 **Duties of the Immediate Past Chief of Staff**
 - 3.5.3.1 Is a member of the MEC of the Medical Staff.
 - 3.5.3.2 Serves as chairman of the Medical Staff Quality Improvement Committee.
- 3.5.4 **Duties of the Secretary-Treasurer**
 - 3.5.4.1 Keeps records of all staff and MEC meetings.
 - 3.5.4.2 Is a member of the MEC of the Medical Staff.
- 3.5.5 **Election of Officers**
 - 3.5.5.1 Officers of the Medical Staff shall be elected at an annual meeting by a majority vote of those members of the Active Staff present at the meeting at the time the vote is taken. The vote shall be by written ballot. Terms of office normally run January 1 through December 31.
 - 3.5.5.2 In any election, if there are three (3) or more candidates for an office and no candidate receives a majority, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority is obtained by one (1) candidate.
 - 3.5.5.3 All officers, except Secretary-Treasurer, shall hold office for a term of two (2) years. The term of office for the Secretary-Treasurer will be one (1) year. The Chief of Staff; and Vice-Chief of Staff may not hold their respective offices for more than two (2) consecutive terms.
 - 3.5.5.4 Vacancies in office during the Medical Staff year, except for the Chief of Staff, shall be filled by the MEC from Active Staff members. If there is a vacancy in the Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term.
 - 3.5.5.5 Any officer of the Medical Staff may be removed by a two-thirds (2/3) vote of the Active Staff. Situations which lead to such a vote may include, but are not limited to, incapacitating illness, permanent revocation of staff privileges, gross dereliction of duties, and indictment for a felony.

3.6 MEETINGS OF THE ACTIVE MEDICAL STAFF MEMBERSHIP

- 3.6.1 Annual Staff Meeting.** The Medical Staff will hold a meeting at which officers and any members at large of the MEC for the ensuing year shall be elected. At that time additional nominations may be received from the floor during election of Staff officers.
- 3.6.2 Quarterly Staff Meetings.** The Medical Staff shall meet four (4) times a year, on dates set by the Chief of Staff, for the purpose of reviewing and evaluating departmental and committee reports and to act on any other matters placed on the agenda by the Chief of Staff. One (1) of these meetings shall be the Annual Meeting.
- 3.6.3 Special Staff Meetings.** Special meetings of the Medical Staff may be called at any time by the Board, the President, the Chief of Staff, a majority of the MEC of the Medical Staff, or a petition signed by not less than ten (10) members of the Active Staff. In the event that it is necessary for the staff to act on a question without being able to meet, the Active Members may be presented with the question by mail and their votes returned to the Chief of Staff by mail. Such a vote shall be binding so long as the question is voted on by a majority of the staff eligible to vote.
- 3.6.4 Notice of Special Meeting.** A written notice stating the place, day, hour and purpose of any special meeting of the Medical Staff shall be mailed to each member of the staff eligible to vote not less than five (5) days before the date of such meeting and shall be posted in the Hospital as required in these Bylaws. The notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to each staff member at his or her address as it appears on the records of the Hospital, or when posted in the Hospital so long as the posting occurs not less than five (5) days prior to the date of that meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.
- 3.6.5 Quorum.** The presence of one-third (1/3) of the members eligible to vote shall constitute a quorum for any regular or special meeting of the Medical Staff. This quorum must exist for any action to be taken. If at any time the presence of a quorum is questioned, a count must be taken. If no quorum is then present, the meeting is adjourned, to be reconvened by the Chief of Staff at a later date. At the discretion of the Chairman of a Department or Committee, quorum may be established utilizing alternate media sources.
- 3.6.6 Agenda.** The agenda at any quarterly Medical Staff meeting should be at the discretion of the Chief of Staff, and should include, but is not limited to, the following items:
- 3.6.6.1** Call to order.
 - 3.6.6.2** Acceptance of the minutes of the last regular and of all intervening special meetings.
 - 3.6.6.3** Report of the MEC.
 - 3.6.6.4** Report of the Board of Directors

- 3.6.6.5 Old Business.
- 3.6.6.6 New Business.
- 3.6.6.7 Department and Committee reports.
- 3.6.6.8 Report from Administration.
- 3.6.6.9 Adjournment.

3.6.7 Reports. Written report of all actions of the MEC shall be included in the MEC's report to the Medical Staff at any quarterly or any special meeting called for this purpose. Any member of the Medical Staff, by proper motion and two-thirds (2/3) majority vote of the Active Staff by written ballot, may require revision of any such action by the MEC at its next meeting. All reports shall be maintained in a permanent file.

3.6.8 Attendance, reports. Each member of the Active Staff shall be required to attend at least fifty percent (50%) of all regular Medical Staff Business Meetings.

3.6.9 Continuing Medical Education. Continuing Medical Education programs shall be held at least five (5) times per year at the discretion of, and under the direction of the Education and Program Committee. Members of the Medical Staff are encouraged to attend education programs.

3.7 DEPARTMENT AND COMMITTEE MEETINGS

3.7.1 Department Meetings

3.7.1.1 Members of each department shall meet as a department at least annually at a time set by the chairman of the department to review and evaluate the quality and appropriateness of the care and treatment provided to patients by the department and to discuss any other matters concerning the department. The agenda for the meeting and its general conduct shall be set by the chairman.

3.7.1.2 Each member of the Active Staff shall be required to attend at least one-third (1/3) applicable department meetings in each year, unless otherwise exempted by their Department Sub Specialty Committee assignment.

3.7.2 Committee Meetings

3.7.2.1 All committees shall meet at least annually, unless otherwise specified, at a time set by the chairman of the committee. The agenda for the meeting and its general conduct shall be set by the chairman.

3.7.3 Special Department and Committee Meetings

3.7.3.1 A special meeting of any committee or department may be called by or at the request of the chairman, by the Chief of Staff, or by a petition signed by not less than one-fourth (1/4) of the members of the department or committee. Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting shall be given to each member of the committee or department not less than five (5) days before the time of such meeting and posted in the Hospital as required by these Bylaws. If

mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member's address as it appears on the records of the Hospital. The attendance of any member at a meeting shall constitute a waiver of the individual's notice of such meeting.

3.7.3.2 In the event that it is necessary for a committee or department to act on a question without being able to meet, the Active members may be presented with the question, in person or by mail, and their vote returned to the chairman of the committee or department. Such a vote shall be binding so long as the question is voted on by a majority of the committee or department eligible to vote.

3.7.4 Quorum. The presence of one fourth (1/4) of the total membership of the committee or department eligible to vote at any regular or special meeting shall constitute a quorum for all actions, except the MEC and any Joint Conference Committee, which shall be one-half (1/2) of the total membership. Once a quorum has been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

3.7.5 Minutes. Minutes of each meeting of each committee and each department shall be prepared and shall include a record of the attendance of members, of the recommendations made and of the votes taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be forwarded to each member of the MEC and to the President, unless otherwise specified for certain committees in Exhibit 2 "Committee List". Each committee and each department shall maintain a permanent file of the minutes of each of its meetings.

3.8 PROVISIONS COMMON TO ALL MEETINGS

3.8.1 Posting Notice of Meetings. Notice of all meetings of the Medical Staff and of departments and committees shall be sent to members at least five (5) days in advance of such meetings.

3.8.2 Attendance Requirements.

3.8.2.1 Each member of the Active Staff shall be required to attend at least fifty percent (50%) of all regular Medical Staff Business Meetings and one-third (1/3) applicable department meetings in each year. A Medical Staff member who is compelled to be absent from any meeting shall promptly submit to the Chairman the reason for such absence if the member desires to receive credit for attendance at that meeting. Credit shall then be at the discretion of the Chairman. The failure of a member to meet the foregoing annual and other attendance requirements, shall at the discretion of the MEC, constitute grounds for action leading to revocation of Medical Staff membership. Reinstatement of staff members whose membership has been revoked because of absence from the required number of staff meetings shall be made only upon

application, and all such applications shall be processed in the same manner as applications for initial appointment.

3.8.2.2 A Medical Staff member whose patient's clinical care is reviewed at a QI Committee and determined to be of concern, may be invited to attend a future meeting to discuss the details of the case. The chairman of the QI Committee shall give the staff member advance written notice of the time and place of the meeting at which his or her attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the staff member shall be notified, that his or her attendance at the meeting at which the alleged deviation is to be discussed is mandatory.

3.8.2.3 The chairman of the applicable department shall notify the MEC of the failure of an individual to attend any meeting with respect to which he or she was given notice that attendance was mandatory, and unless excused by the MEC upon showing of good cause, such failure shall result in an automatic suspension of all or such portion of the individual's admitting privileges as the MEC may direct and such suspension shall remain in effect until the matter is resolved. In all other cases, if the individual shall make a timely request for postponement supported by an adequate showing that his or her absence will be unavoidable, such presentation may be postponed by the chairman of his or her department or by the MEC, if the department chairman is the individual involved, until not later than the next regularly scheduled meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

3.9 RULES OF ORDER. Wherever they do not conflict with these Bylaws, the latest edition of Robert's Rules of Order shall govern all meetings.

4. DEPARTMENTS OF THE MEDICAL STAFF

4.1 List of Departments. The following departments are established: Anesthesia, Emergency Medicine, Family Medicine, Medicine, Pathology, Pediatrics, Psychiatry and Addictions, Radiology, and Surgery. Additional departments, as required from time to time, may be established by the Board after recommendations from the MEC of the Medical Staff.

4.2 Functions of Departments:

4.2.1 Each department shall establish its own written criteria for the assignment of clinical privileges. Such criteria shall be consistent with these Bylaws, the policies of the Medical Staff and of the Board. Clinical privileges shall be based upon demonstrated training and experience within the field covered by the department.

4.2.2 Each department shall establish its own criteria for the provision of emergency care.

4.2.3 Family Medicine Department

4.2.3.1 A member of the Department of Family Medicine shall be granted privileges in one (1) or more clinical departments in accordance with his or her background, education, experience, training and

demonstrated competence and other criteria in the same manner as any other member of the staff. He or she shall be subject to the rules and regulations of such departments.

4.2.3.2 The Chief of the Family Medicine Department shall assign yearly one (1) member of his or her department to the Department of Pediatrics as a liaison for the purpose of attending and participating in the various departmental meetings. Family Physicians and Allied Health Providers with Obstetrics Privileges are required to attend Perinatology Committee (a division of the Surgery Department) meetings.

4.2.4 Each department shall be responsible for conducting a review of completed records and other pertinent departmental sources of medical information relating to patient care. Such review shall include consideration of selected deaths, unimproved patients, errors in diagnosis and treatment, and such other instances as are believed to be of interest.

4.2.5 The Department of Surgery and the Perinatology Committee shall also conduct a comprehensive surgical-pathological review for justification of surgery performed, whether or not tissue was removed, and to evaluate the acceptability of the procedure chosen for the surgery. Specific consideration shall be given to the agreement or disagreement of the preoperative and pathological diagnoses.

4.2.6 In discharging these functions each department shall report to the MEC and/or the Medical Staff Quality Improvement Committee detailing its analysis of patient care.

4.3 Department Chairman

4.3.1 The chairman of each department shall be a member of the Active Staff of the department.

4.3.2 The chairman shall be certified by an appropriate specialty board, or have comparable competency, as determined through the credentialing and privileging process set forth in these Bylaws.

4.3.3 The chairman and vice-chairman of each department shall be selected by the department for a period of at least one (1) year with no restrictions on the number of terms.

4.3.4 Removal of the chairman during his or her term of office may be by a two-thirds (2/3) vote of the Active Staff of the department.

4.4 Function of Department Chairman

4.4.1 Be responsible for the organization of all Medical Staff activities of his or her department and for the general administration of his or her department.

4.4.2 Be a member of the MEC.

4.4.3 Review the professional performance of all individuals with clinical privileges in his or her department and report and recommend thereon to the MEC when appropriate.

4.4.4 Be responsible for enforcement within his or her department of the Hospital Bylaws and of the Medical Staff Bylaws, rules and regulations.

- 4.4.5 Be responsible for implementation within his or her department of actions taken by the Board and the MEC of the Medical Staff.
- 4.4.6 Transmit to the Credentials Committee the recommendations concerning the appointment, reappointment and delineation of clinical privileges for all individuals in and applicants to his or her department; this statement shall give consideration to each individual's general health status.
- 4.4.7 Be responsible for the establishment, implementation and effectiveness of the teaching, education and research program in his or her department.
- 4.4.8 Report and recommend to Hospital management when necessary with respect to matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques.
- 4.4.9 Assist the Hospital management in the preparation of annual reports and such budget planning pertaining to his or her department as requested by the President or the Board.
- 4.4.10 Establish divisions within the department subject to the approval of the MEC, and appoint chiefs thereof.
- 4.4.11 Be accountable for all professional and administrative activities within the department.
- 4.4.12 Recommend to the Medical Staff the criteria for clinical privileges in the department.
- 4.4.13 Assure that the quality and appropriateness of patient care provided within the department are monitored and evaluated.

5. COMMITTEES OF THE MEDICAL STAFF

5.1 APPOINTMENT

Chairmen. Appointment of all committee chairmen, except the MEC, will be made by the Chief of Staff-elect annually. All chairmen shall be selected from among members of the Active Staff.

5.1.1 **Members.** Members of each committee, except as otherwise provided for in these Bylaws, shall be appointed yearly by the Chief of Staff-elect, with no limitation in the number of terms they may serve. All appointed members may be removed and vacancies filled by the Chief of Staff at his or her discretion.

5.1.2 The President or his or her designee may attend and participate in meetings of any Medical Staff committee, ex officio.

5.2 OPTIONAL GROUPS

5.2.1 Practitioners may organize themselves into, or be appointed to, a specific function, a task force or ad hoc committee group. Any group will not be required to hold any number of regularly scheduled meetings, nor will attendance be required unless the group chairperson calls a special meeting to discuss a particular issue.

5.2.2 Groups may perform any of the following activities: Continuing education; Grand rounds; Discussion of policy; Discussion of equipment needs; Development of recommendation for department chairperson or MEC;

Participation in the development of criteria for clinical privileges; Discuss a specific issue at the special request of a department chairperson or the MEC.

- 5.2.3 No minutes or reports will be required except when making a formal recommendation to a department or the MEC documenting the group-specific position.
- 5.2.4 Group meetings will not require attendance to be taken or any rigid agenda to be followed. They will ordinarily not be staffed or assisted by representatives of the Medical Staff office.

5.3 MEDICAL EXECUTIVE COMMITTEE

5.3.1 The MEC shall consist of the officers of the Medical Staff, the Chairman of the Credentials Committee, the two (2) Medical Staff Representatives to the Board, the chairman of each department, and two (2) members elected at-large from the Active Staff.

5.3.1.1 The two (2) MEC members-at-large shall be elected at the Annual Medical Staff meeting for a term of two (2) years in such a manner that their terms shall be staggered. Of the nominees who shall be presented by the Nominating Committee and any others nominated from the floor, the one (1) receiving the largest number of votes shall be elected. At-large members shall be eligible for reelection, but shall not serve more than three (3) consecutive terms. Vacancies in office during the term shall be filled by the MEC from Active Staff members.

5.3.1.2 The President and his or her staff and members of the Board may attend meetings of the MEC and participate in the discussion but without vote.

5.3.1.3 Any Active Staff member may attend meetings, ex officio, without vote.

5.3.1.4 The vice chairman of a department may attend the MEC in lieu of the chairman at the request of his or her department chairman, may vote, and may count towards establishment of a quorum.

5.3.2 Duties

5.3.2.1 Represent and act on behalf of the Medical Staff in all matters between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws.

5.3.2.2 Coordinate the activities and general policies of the various departments.

5.3.2.3 Receive and act upon committee reports, and make recommendations concerning them to the President and the Board.

5.3.2.4 Implement policies of the Medical Staff which are not the responsibility of the departments.

5.3.2.5 Provide liaison among Medical Staff, the President and the Board.

5.3.2.6 Recommend action to the President on matters of a medico-administrative and Hospital management nature.

EGH MEDICAL STAFF BYLAWS

- 5.3.2.7 Ensure that the Medical Staff is kept abreast of the appropriate external accreditation program and informed of the accreditation status of the Hospital;
- 5.3.2.8 As a Peer Review Committee, take all reasonable steps to ensure professionally ethical conduct and the enforcement of Hospital and Medical Staff rules in the best interest of patient care and of the Hospital on the part of all members of the Medical Staff, and to make recommendations to the Board on actions described in section 7.
- 5.3.2.9 As a Peer Review Committee, refer situations involving questions of the clinical competence, patient care and treatment or case management of any individual members of the Medical Staff to the Credentials Committee for review and recommendation.
- 5.3.2.10 Recommend to the Board modifications in the structure of the Medical Staff, mechanisms used to review credentials and delineate clinical privileges, and mechanisms for the provisions of hearings related to Medical Staff membership.
- 5.3.2.11 The Chairman of the MEC, his or her representative and such members of this committee as he or she deems necessary, shall be available to meet with the Board or its applicable committee on all recommendations that the MEC may make, it being the purpose of these Bylaws to increase direct communication between the Board and the MEC on all matters within the scope of the MEC's duties.

5.3.3 Meetings, Reports and Recommendations. The MEC shall meet as often as necessary to fulfill its responsibility and maintain a permanent record of its proceedings and actions. Special meetings may be called at any time by the Chief of Staff. Reports of all meetings shall be maintained, and shall include the minutes of the various committees and departments of the Staff. Copies of all minutes and reports of the MEC shall be transmitted to the President routinely as prepared, and actions of the MEC shall be reported to the staff as a part of the MEC's report at quarterly staff meeting. Recommendations and actions of the MEC shall be transmitted to the President and to the Board of Directors through the Chief of Staff as the Committee deems appropriate.

5.4 CREDENTIALS COMMITTEE

5.4.1 Composition. The Credentials Committee shall consist of at least five (5) members of the Active Staff who, as much as practical shall be from different departments, and, if practical, shall not be serving simultaneously as either chairman of a department or officer of the staff; and with no more than two from any one department. The Chairman of each Medical Staff department will be notified seven (7) calendar days prior to the meeting of the agenda items. The Credentials Committee in all of its functions is a Peer Review Committee and shall maintain its records and deliberations in confidence and shall be accorded the privileges granted by the Indiana Peer Review Act. The Credentials

Committee will identify a member of the Committee as Credentials Committee Vice Chairman.

5.4.2 Duties.

- 5.4.2.1** Review the credentials of all applicants, make such investigations and interview all applicants as may be necessary, and make recommendations for appointment and delineation of clinical privileges in compliance with these Bylaws to the MEC.
- 5.4.2.2** Review periodically on their own motion or as questions arise all information available regarding the professional and clinical competence of staff members, their care and treatment of patients and case management, and as a result of such review, make recommendations for the granting, reduction or withdrawal of promotions, privileges, reappointments, and changes in the assignment of staff members to the various departments.
- 5.4.2.3** Review reports on specific members of the Medical Staff that are referred by the MEC.
- 5.4.2.4** Meetings, Reports and Recommendations. The Credentials Committee shall meet as necessary and shall maintain a permanent record of its proceedings and actions and shall report its recommendations to the MEC.

5.5 MEDICAL STAFF QUALITY IMPROVEMENT COMMITTEE

5.5.1 Composition.

- 5.5.1.1** The Medical Staff Quality Improvement Committee will consist of the Chief of Staff, Vice Chief of Staff, and the most recent three Past Chiefs of Staff who have active staff status. Non-voting ad hoc members will be the Hospital President, the Vice President of Medical Staff Affairs, the Vice President of Nursing, and the Medical Staff/Quality Improvement Coordinator. One member of the Medical Staff will be appointed to a two year term by the MSQIC members to serve as an additional Medical Staff Quality Improvement Committee member. This individual will be selected from volunteers, but must have previously served as a member of MSQIC.
- 5.5.1.2** The most recent Past Chief of Staff will serve as the Chairman of the Medical Staff Quality Improvement Committee.
- 5.5.1.3** The Chairman shall establish agenda for the meetings.

5.5.2 Duties.

- 5.5.2.1** Monitor the quality of care rendered to patients in the Hospital and make recommendations to appropriate departments, practitioners, the MEC, or the administration of the Hospital regarding improvements necessary in the rendition of quality care.

- 5.5.2.2 Engage in reviews and evaluation of patient care and report the findings of said reviews and evaluations to the departments affected.
- 5.5.2.3 Confer with and counsel individual practitioners concerning appropriate standards and quality of care where appropriate.
- 5.5.2.4 Recommend to the MEC any specific or general disciplinary action or sanction deemed necessary and appropriate to facilitate improvements in patient care.
- 5.5.2.5 Perform such other functions as are specifically authorized and set out in the Quality Improvement Program which program is incorporated herein by reference to these Bylaws.

5.6 **MEETINGS, REPORTS AND RECOMMENDATIONS.** The Quality Improvement Committee shall meet as necessary and shall maintain a permanent record of its proceedings and actions in the Medical Staff Peer Review files, and shall report its recommendations to the MEC.

5.7 **SPECIAL COMMITTEES.** Special committees shall be appointed by the Chief of Staff as they are required. Such committees shall define their activities to the purpose for which they were appointed, and shall report to the MEC.

5.8 **STANDING "OTHER" COMMITTEES.** The provisions under this Article V concerning committees should be read in concert with the Medical Staff Committee List attached hereto as Exhibit "2". To the extent the provisions under this section 5 are irreconcilable or in conflict with the provisions of the Medical Staff Committee List, the provisions of the Medical Staff Committee List shall take precedence.

6. APPOINTMENT

6.1 QUALIFICATIONS FOR APPOINTMENT TO THE MEDICAL STAFF.

Applicants for appointment and reappointment to the Medical Staff must establish and continuously meet the following qualifications:

6.1.1 The applicant must be a physician with an unlimited license to practice medicine in the State of Indiana, or be a licensed oral maxillofacial surgeon.

6.1.2 Board certification.

6.1.2.1 The applicant must be a physician or dentist certified by the appropriate specialty board and subspecialty board, if applicable, of the American Board of Medical Specialties, American Osteopathic Association, or American Dental Association (if such certifying board exists), in his or her area of primary practice and in which privileges are requested. Physicians applying for appointment to the Elkhart General Hospital Medical Staff must have fulfilled the training requirements concerning board admissibility for examination for certification, in his or her area of primary practice and in which privileges are requested, and thereafter become certified within five (5) years of completion of training. Medical Staff members must remain board certified for the duration of their membership on this staff. Physician applicants practicing in the

EGH MEDICAL STAFF BYLAWS

field before joining the Medical Staff for more than 3 years after the completion of their training must be board eligible and obtain their board certification within two (2) years from the time they join the medical staff.

- 6.1.2.2 Current members of the Medical Staff who are currently board certified must retain their board certification for the duration of their membership on this staff. Current members of the Medical Staff have two (2) years from the time their board certification lapses to recertify as long as they show they are actively attempting recertification. If they fail to pass a recertification, they must follow their specialty board's requirements for completing recertification, or be recertified within two (2) years if their specialty board does not have any specific requirements.
 - 6.1.2.3 Current members of the Medical Staff who were neither board certified nor board eligible, and grandfathered by the EGH Medical Staff as members, will be required to provide proof of sixty (60) CME hours every two (2) years at reappointment.
 - 6.1.2.4 Current members of the Medical Staff who did not have the possibility of board certification when they got their medical degree will be grandfathered as members of our Medical Staff.
 - 6.1.2.5 Current members of the Medical Staff who had the possibility of board certification but chose not to get it, will be referred to their Department to decide whether to grandfather them, or to set standards that need to be met to continue as a member of the Medical Staff.
- 6.1.3 The applicant must document his or her background, experience, training and demonstrated competence, completion of an American Medical Association (A.M.A.) or American Osteopathic Association (A.O.A.) approved residency, or approved equivalency, or be American Board-certified, his or her adherence to the ethics of his or her profession, his or her ability to work with others, and, as requested, his or her health status so as to demonstrate that all patients treated by him/her in the Hospital shall receive quality medical care. Osteopathic physicians subscribe to and utilize the distinctive osteopathic approach in the provision of care. The MEC of the Medical Staff at its discretion may recommend to the Board the waiver of any of these requirements of eligibility if in its absolute discretion it determines that an applicant has exceptional alternate qualifications which serve as an adequate academic and clinical substitute for any specified requirement. Such discretion shall be utilized only in extraordinary circumstances.
- 6.1.4 The applicant must be and remain a qualified health care provider under the Indiana Medical Malpractice Act (I.C. 34-18 *et seq*) and provide to the Hospital proof of coverage for professional liability insurance with limits at least equal to the minimum limits provided for in said Act and proof of payment of the necessary annual surcharge.

- 6.1.5 The applicant must demonstrate his/her ability to render quality medical care in such a manner that recognizes and is consistent with community standards and national guidelines.
- 6.1.6 The applicant must demonstrate to the satisfaction of the Medical Staff a willingness and capability based on current attitude and evidence of performance, to work collegially and professionally with and relate to other staff members, residents and students, members of other health disciplines, hospital management and administration, employees, visitors and the community in general in a cooperative, professional manner that is essential for maintaining a hospital environment appropriate to quality patient care.
- 6.1.7 The applicant shall reside and have his or her practice in the community of Elkhart, Indiana, or within a reasonable distance from the Hospital to be reasonably able to render necessary care to his or her patients including emergency (as defined by EMTALA) backup coverage and postsurgical complication care and so as to permit the applicant to assume and perform all the responsibilities and duties of Medical Staff membership.
- 6.1.8 The applicant must meet such other criteria as established by the Hospital which shall include the ability of the Hospital to provide adequate facilities and supportive services for the applicant and his or her patients and shall include the patient care needs for additional staff members with the applicant's skill and training.
- 6.1.9 The applicant shall not be denied appointment on the basis of his or her sex, race, creed, color, national origin disability, or other considerations not impacting applicant's ability to discharge the privileges for which he or she has applied.
- 6.1.10 The applicant must agree that he or she will strictly abide by the Principles of Medical Ethics of the American Medical Association, American Osteopathic Association, or the American Dental Association whichever is applicable.
- 6.1.11 No applicant shall be entitled to appointment of the Medical Staff or the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he or she is duly licensed to practice medicine or osteopathic medicine in the State of Indiana or any other state, or that he or she has in the past, or currently has, Medical Staff membership or privileges at another hospital.
- 6.1.12 Members of the Medical Staff and those who have been assigned clinical privileges and who have contractual relationships with the Hospital will be governed by the provisions of those agreements as well as by the Medical Staff Bylaws and the Bylaws of the Hospital.

6.2 **CONDITIONS OF APPOINTMENT**

- 6.2.1 **Duration of Initial Provisional Appointment** All initial appointments to the Medical Staff and all initial clinical privileges, unless provided by the Board, shall be provisional, for a period of at least one (1) full year. All newly appointed staff members as part of their provisional status shall be assigned to a department where their performance shall be specifically evaluated by the chairman of the department and the department's quality improvement committee to determine the eligibility of members for reappointment and to recommend continuation,

decrease or increase of the clinical privileges granted to them during the term of the provisional appointment.

- 6.2.2 Clinical Privileges Appointment to the Medical Staff or the assignment of clinical privileges shall confer on the appointee only such clinical privileges as have been granted by the Board in accordance with these Bylaws.
- 6.2.3 Applicant's Pledge. All members of the Medical Staff will be required to pledge to refrain from fee-splitting or other inducements relating to patient referral, to provide for continuous care of his or her patients, to refrain from delegating the responsibility for diagnosis or care of hospitalized patients to another practitioner who is not qualified to undertake this responsibility and who is not adequately supervised, to seek consultation whenever necessary and to refrain from providing "ghost" surgical or medical services.
- 6.2.4 The following basic responsibilities and representations shall be applicable to every applicant initially requesting clinical privileges and member considered for renewal of privileges as a condition of considering his or her application.
 - 6.2.4.1 An obligation to provide appropriate continuous care and supervision, according to granted hospital privileges, to all patients within the Hospital for whom the individual has responsibility.
 - 6.2.4.2 An agreement to abide by the Medical Staff Bylaws, all clinical Hospital policies, the Hospital Governing Bylaws and Related Manuals;
 - 6.2.4.3 An agreement to accept Medical Staff committee assignments and such other reasonable duties and responsibilities as shall be assigned.
 - 6.2.4.4 Be available for unassigned (those who present for medical care with no established physician relationship) hospitalized/admitted/ patients placed in observation, or as defined by EMTALA according to granted privileges.
 - 6.2.4.5 An obligation to use the Hospital and its facilities sufficiently to allow the Hospital, through assessment by appropriate Medical Staff committees and department chairpersons, to evaluate in a continuing manner the current competence of the member;
 - 6.2.4.6 An agreement that the hearing and appeal procedures set forth in the Fair Hearing Plan shall be the sole and exclusive remedy with respect to any professional review action taken at the Hospital; and
 - 6.2.4.7 An agreement to abide by all emergency service call policies (as defined by EMTALA) of the Hospital and Medical Staff, including the Bylaws and Related Manuals, and such other reasonable duties and responsibilities as assigned.
 - 6.2.4.8 An agreement to provide to the Hospital, with or without request, and, as it occurs, new or updated information that is pertinent to any question on the application form.

6.2.5 It shall be the responsibility of all Members to notify the Credentials Committee or its designee of any actions taken against him or her with respect to medical staff appointment, clinical privileges, licensure, certification, or criminal charges, as soon as possible, but no more than thirty (30) days following such.

6.2.6 Abide by all rules. All members of the Medical Staff shall abide by the Medical Staff Bylaws, Rules and Regulations, and Policies; the Hospital Bylaws, Rules and Regulations, Performance Improvement Plan, Patient Safety Program, Utilization Management Plan, Risk Management Plan, and Policies, as in existence at the time of appointment and as amended from time to time.

6.3 APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

6.3.1 Information. Applications for appointment to the Medical Staff shall be in writing, and shall be submitted on forms agreed upon by both the Board and the Medical Staff. These forms shall be obtained from the President or his or her designee. The application shall require detailed information concerning the applicant's professional qualifications including:

- 6.3.1.1** the names of at least two (2) physicians or oral maxillofacial surgeons, as appropriate, who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character;
- 6.3.1.2** information as to whether the applicant's Medical Staff appointment and/or clinical privileges have ever been revoked, suspended, reduced or not renewed at any other hospital or health care facility; whether the applicant has been subject to any reviews such as quality assurance action, intensified review; and, whether or not the applicant has ever voluntarily relinquished Medical Staff membership and/or clinical privileges at any other hospital or health care facility;
- 6.3.1.3** information as to whether his or her membership in local, state or national medical societies or his or her license to practice any profession in any state, or his or her narcotic license has ever been suspended, terminated, voluntarily relinquished, or subject to complaint or investigation by the appropriate licensing agency. The submitted application shall include a copy of the applicant's current license to practice as well as his or her narcotics license;
- 6.3.1.4** information concerning the applicant's malpractice experience including details regarding all past and current claims for ten (10) years immediately preceding the date of application;
- 6.3.1.5** a consent to the release of information from his or her present and past malpractice insurance carriers;
- 6.3.1.6** a request for the clinical privileges desired by the applicant;
- 6.3.1.7** information concerning whether the applicant has ever been referred to a Physicians Assistance Committee and the details of

EGH MEDICAL STAFF BYLAWS

said referral. This subsection does not apply to existing members of the Medical Staff but only to initial appointment. This subsection shall apply to information during the preceding ten (10) years period prior to the date of application;

6.3.1.8 the National Practitioner Data Bank will be queried; and,

6.3.1.9 a criminal background check may be requested at initial appointment.

6.3.2 Undertakings. Every application for Medical Staff appointment shall be signed by the applicant and shall contain:

6.3.2.1 the applicant's specific acknowledgment of the obligation upon appointment to the Medical Staff to provide continuous care and supervision, according to granted privileges, to all patients within the Hospital for whom he or she has responsibility;

6.3.2.2 his or her agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him/her by the Board and the Medical Staff;

6.3.2.3 a statement that the applicant has received and read a copy of such Bylaws of the Hospital and Bylaws, rules and regulations of the Medical Staff and department to which he or she will be assigned privileges and the Hospital's Performance Improvement Plan, and that he or she has agreed to be bound by the terms thereof as currently constituted and as amended from time to time;

6.3.2.4 a statement of his or her willingness to appear for personal interviews in regard to his or her application;

6.3.2.5 a consent authorizing the Hospital and Medical Staff to consult with members of the medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his or her competence, character and ethical qualifications; and,

6.3.2.6 a consent authorizing the Hospital and Medical Staff to inspect the records and documents that may be material to an evaluation of his professional qualifications and competence to carry out the clinical privileges he or she requests, as well as his or her moral and ethical qualifications for staff membership.

6.3.3 Burden of Providing Information

6.3.3.1 The applicant shall have the burden of producing adequate information as determined by the Medical Staff for a proper evaluation of his or her competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications. He or she also has the burden of providing evidence that all the statements made and information given on the application are factual and true.

6.3.3.2 No application will be forwarded to the Credentials Committee, MEC or Board for consideration until all information requested by the Medical Staff has been provided and is substantially complete. The President or his or her designee shall notify the applicant of any material lacking, and it shall be the applicant's duty to supply such material.

6.3.4 Statement of Release and Immunity from Liability

6.3.4.1 To the fullest extent permitted by law the applicant releases from civil liabilities all authorized representatives of the Hospital and Medical Staff for any acts, communications, reports, recommendations, or disclosures performed, made or received in good faith, concerning activities relating to:

6.3.4.2 Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the supplication are accurate. The making of a false statement in the application is grounds for denial of the application. The term "false statement" includes, without limitation, the making of a false statement of any material or the failure to state or disclose a material fact.

6.3.4.3 applications for appointment or clinical privileges, including interim privileges;

6.3.4.4 periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;

6.3.4.5 proceedings for suspension of clinical privileges or revocation of staff membership;

6.3.4.6 summary suspension;

6.3.4.7 all actions affecting the privileges or status of a Medical Staff member and the hearings and appellate review procedures relating thereto;

6.3.4.8 other Hospital, departmental, or committee activities conducted under Hospital auspices relating to the quality of patient care or the professional conduct of a physician or dentist; and,

6.3.4.9 release of information to other medical institutions professional organizations and/or licensing boards regarding the applicant's professional qualifications or competency.

6.4 **PROCEDURE FOR INITIAL APPOINTMENT**

6.4.1 Submission of Application. The completed application for Medical Staff appointment shall be submitted by the applicant to the President or his or her designee. The President or his or her designee shall transmit the application and all supporting materials to the Credentials Committee for evaluation.

6.4.2 Initial Credentials Committee Procedure. Upon receipt of the completed application for appointment the Credentials Committee shall;

EGH MEDICAL STAFF BYLAWS

- 6.4.2.1 inform the chairman of each department in which the applicant seeks clinical privileges of the pending application, furnish a copy of the application and supporting materials to each chairman concerned and request recommendations;
- 6.4.2.2 post the name of the applicant on the bulletin board so that each member of the Medical Staff may have an opportunity to submit to the Committee, in writing, information bearing on the applicant's qualifications for staff membership. In addition, any member of the Medical Staff shall have the right to appear in person before the Credentials Committee to discuss in private and in confidence any concerns he or she may have about the applicant.
- 6.4.3 **Department Chairman Procedure.** The chairman of each department in which the applicant seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for approving or disapproving the application and for delineating the applicant's clinical privileges. These recommendations shall be made a part of the Credentials Committee's report. As part of the process of making its recommendation, the department chairman may meet with the applicant to discuss any aspect of his or her application, his or her qualifications and his or her clinical privileges.
- 6.4.4 **Subsequent Credentials Committee Procedure.**
 - 6.4.4.1 The Credentials Committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in reference given by the applicant and from other sources available from the chairman of the clinical department in which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the category of Medical Staff membership and clinical privileges requested by him/her.
 - 6.4.4.2 Where appropriate, as part of this process, the Credentials Committee may require an impartial physical or mental examination of the applicant and shall require that the results be made available for the Committee's consideration.
 - 6.4.4.3 As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss any aspect of his or her application, his or her qualifications and his or her clinical privileges.
 - 6.4.4.4 After considering the recommendations of the clinical departments concerned, the Credentials Committee shall recommend provisional department assignments and provisional clinical privileges for all Medical Staff applicants and for all other approved individuals with clinical privileges.
- 6.4.5 **Credentials Committee Report.** Within sixty (60) days after receipt of the completed application for membership from the President, the Credentials Com-

mittee shall make a written report and recommendation on the applicant to the MEC.

6.4.6 MEC Procedure.

- 6.4.6.1** At its next regular meeting after receipt of the application, report and recommendation of the Credentials Committee, the MEC shall determine whether to recommend to the Board that the applicant be appointed to the Medical Staff, that his or her application be deferred for further consideration, or that he or she be rejected for staff membership.
- 6.4.6.2** When the recommendation of the MEC is favorable to the applicant, the President shall promptly forward it, together with all supporting documentation, to the Board. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges. When the recommendation of the MEC is to defer the application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for appointment to staff membership with specified clinical privileges, or for the rejection of the application for staff membership. Prior to, and in furtherance of, any such subsequent recommendation, the MEC can, at its discretion, direct the Credentials Committee to further investigate any aspect of the application or direct the Credentials Committee to otherwise act so as to enable the MEC to make a subsequent recommendation concerning the application.
- 6.4.6.3** When the recommendation of the MEC is adverse to the applicant in respect to either appointment or clinical privileges, the President shall promptly so notify the applicant by certified mail, return receipt requested. The MEC shall then hold the application until after the applicant has exercised or has been deemed to have waived his or her right to a hearing as provided in section 9. Whenever the applicant has been deemed to have waived his or her right to a hearing the President shall forward the recommendation of the MEC, together with all supporting documentation, to the Board. If the applicant requests a hearing, the recommendation of the Hearing Committee shall be made to the MEC.
- 6.4.6.4** If, after the MEC has considered the report and recommendation of the Hearing Committee and the hearing record, the MEC's reconsidered recommendation is favorable to the applicant, the President shall promptly forward it, together with all supporting documentation, to the Board. If such recommendation continues to be adverse, the President shall then forward such recommendation, together with all supporting documentation, to the Board.

- 6.4.6.5 When final action has been taken by the Board, the President of the Hospital shall be authorized to notify the applicant of this decision and, if he or she has been accepted, to secure his or her signature to the Bylaws, Rules and Regulations, and Policies of the Medical Staff and of the Hospital, and of the Hospital's Performance Improvement Program. Such signature shall constitute willingness to be bound by all of said documents.
- 6.4.6.6 The Board shall report all final actions to the National Practitioner Data Bank and Medical Licensing Board of Indiana as required by applicable federal and state law. Denial of appointment or clinical privileges due to a failure to meet threshold or objective requirements or for reasons that do not relate to the competence or professional conduct of a physician or dentist as defined under the Health Care Quality Improvement Act are not reportable to the National Practitioner Data Bank.

7. CLINICAL PRIVILEGES

7.1 CLINICAL PRIVILEGES DELINEATED

- 7.1.1 Every physician or oral maxillofacial surgeon practicing at this Hospital by virtue of Medical Staff membership or otherwise, shall in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Board of Directors, except as provided in section 7.3 and 7.4 of this section.
- 7.1.2 Every initial application for Staff appointment must contain a request for specific clinical privileges desired by the applicant. The two categories of clinical privileges are: Active Core Privileges (which are specified according to specialty and department) or Refer and Follow privileges.
- 7.1.3 The evaluation of requests for Active Core Privileges shall be based upon the applicant's education, training and experience, demonstrated competence, references and other relevant information, including an appraisal by the department in which such privileges are sought. The applicant shall have the burden of establishing his or her qualifications and competence in the clinical privileges that he or she requests.
- 7.1.4 Refer and Follow privileges allow the physician to visit his or her patients in the hospital, review the medical record, and provide advice to physicians, nurses and other healthcare providers involved with the care of these patients. Physicians with Refer and Follow privileges cannot give verbal orders or place orders on the hospital chart or perform any procedure for patients admitted to the hospital or placed in observation at the hospital.
- 7.1.5 Active and Courtesy Members of the Medical Staff who desire "Refer and Follow" privileges must have a contractual agreement with another physician or group of physicians who do have Active Core Privileges and will care for patients placed in observation or admitted to the hospital who belong to the practice of the "Refer and Follow" physician. Participation in the Hospitalist Program of Elkhart General Hospital requires a contractual agreement.

- 7.1.6 Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of patients treated in this or other hospitals and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care.
- 7.1.7 Any professional review action that adversely affects the clinical privileges of a physician or a dentist longer than thirty (30) days will be reported to the Medical Licensing Board of Indiana within (15) days. Any voluntary surrender of medical staff membership or clinical privileges of a physician or dentist will be reported to the Medical Licensing Board of Indiana if the physician or dentist is under investigation for possible incompetence or improper professional conduct, or if the surrender is in lieu of an investigation. Denial of clinical privileges due to a failure to meet threshold requirements (e.g. board certification) will not be reported. Denial related to competence or professional conduct will be reported.
- 7.2 **NON-REPORTABLE ACTIONS.** Examples of actions that are not reportable to the Medical Licensing Board of Indiana or the National Practitioner Data Bank include, but are not necessarily limited to:
 - 7.2.1 Denial of clinical privileges or Medical Staff membership based on a closed Medical Staff or exclusive contract arrangement which foreclose any practitioner from providing those services within the facility except those members of the exclusive group.
 - 7.2.2 Suspension, denial or non-renewal of clinical privileges or medical staff membership due to a failure to obtain or maintain professional liability insurance at a specified level as determined by the MEC.
 - 7.2.3 Denial of clinical privileges or Medical Staff membership based on failure to comply with threshold or objective eligibility requirements such as Board certification, geographic proximity to the Hospital or other non-competency-based requirement.
 - 7.2.4 Reduction or non-renewal of clinical privileges or Medical Staff membership due to a practitioner's failure to meet new eligibility requirements or Bylaws requirements.
 - 7.2.5 Reduction or failure to renew clinical privileges or Medical Staff membership due to the Medical Staff's requirement that the physician have a minimum number of patient contacts.
- 7.3 **TELEMEDICINE CLINICAL PRIVILEGES**
 - 7.3.1 Appointment to Medical Staff. Applicants seeking appointment to the Medical Staff and/or clinical privileges to perform telemedicine services may, but need not, be processed pursuant to the complete appointment and privileging procedures described in Sections 6 and 8 of these Bylaws. Further, such applicants may be exempted by the MEC from particular Medical Staff requirements/obligations that are not applicable by virtue of the applicant's practitioner's distant site practice (including but not limited to vaccination requirements, meeting attendance requirements, and other such requirements/obligations). Alternatively, in the case of applicants who intend to

provide telemedicine services under a written agreement between the Hospital and a distant-site hospital or entity, the MEC may make recommendations to the Board regarding such applicants in reliance upon the credentialing and privileging decision of the distant-site hospital or entity with whom the Hospital has an agreement for telemedicine services.

7.3.2 Applicants from Distant-Site Hospitals. Applicants based at distant-site hospitals or entities who intend to provide telemedicine services under a written agreement with the Hospital may apply for such telemedicine clinical privileges and appointment to the Affiliate Staff provided each applicant meets the essential qualifications for appointment set forth in Section 6.1, above, and by submission of the same application or application with equivalent content as specified in Sections 6.3 and 8.1 of these Bylaws (as applicable). All determinations regarding equivalent content will be made by the MEC and Board.

7.3.3 Credentialing of Applicants from Distant-Site Hospitals. Upon confirmation that an applicant's request for appointment and telemedicine privileges complies with the terms of the written agreement between the Hospital and the distant-site hospital or entity, including clinical privileges criteria adopted by the Medical Staff, the MEC may rely upon the credentialing and privileging decisions made by a distant-site hospital or telemedicine entity when making its recommendation for appointment and clinical privileges provided the agreement between the Hospital and distant-site hospital or entity ensures the following:

7.3.3.1 The distant-site hospital is a Medicare participating hospital or the distant-site telemedicine entity provides written assurances that its credentialing and privileging process and standards meet the Medicare Conditions of Participation for Hospitals;

7.3.3.2 The distant-site hospital or distant-site telemedicine entity, as applicable, meets all other Joint Commission or other pertinent accreditation requirements to which the Hospital may be subject;

7.3.3.3 The applicant/practitioner is privileged at the distant-site hospital or distant-site telemedicine entity and a current list of equivalent privileges is provided;

7.3.3.4 The distant-site applicant/practitioner holds a current license issued or recognized by the State of Indiana;

7.3.3.5 The applicant/practitioner meets the professional liability insurance requirements established by the Board; and

7.3.3.6 That upon being granted membership and/or clinical privileges, the Hospital provides the distant-site hospital or entity evidence of an internal review of the practitioner's clinical performance for use in the practitioner's periodic appraisal and, at a minimum, the information must include all adverse events resulting from the telemedicine services provided by the distant-site practitioner as well as any registered complaints.

7.3.4 Failure to Utilize Clinical Privileges. If a practitioner who has been granted clinical privileges to provide telemedicine services at the Hospital fails to utilize

such clinical privileges or otherwise provide telemedicine services to Hospital patients at a satisfactory volume as determined by the practitioner's assigned Department for the purpose of reliably assessing the quality and performance of the practitioner's telemedicine services, the member shall be deemed to have voluntarily withdrawn his or her Medical Staff membership and clinical privileges, without right of appeal or hearing, effective either six (6) months following the date practitioner last provided telemedicine services at the Hospital or when otherwise acknowledged by the Medical Staff.

- 7.3.5 Temporary Clinical Privileges for Telemedicine Applicants. If the Hospital has not entered into a written agreement for telemedicine services with a distant-site hospital or entity but has a pressing clinical need for telemedicine services and a distant-site practitioner can supply such services via a telemedicine link, the Hospital may evaluate the use of temporary clinical privileges for a distant-site practitioner as addressed in Section 7.4 below. In such cases, the distant-site practitioner must be credentialed and privileged to provide telemedicine services in accordance with Hospital standards and procedures applicable to the approved telemedicine services.

7.4 TEMPORARY CLINICAL PRIVILEGES

- 7.4.1 **Circumstances.** The Hospital President, acting on behalf of the Governing Board, may grant specific temporary clinical privileges in only the following circumstances. Provided, however, unless otherwise set forth in applicable Hospital policy, that temporary clinical privileges may not be granted unless an applicant successfully completes any Hospital sponsored training programs related to electronic medical record (EMR) and related clinical system implementation, passes any related program examination or opt-out examination and submits required program documentation prior to review of request for temporary admitting and clinical privileges by Department Chairperson.

7.4.1.1 **Pendency of Application.** Upon receipt of a signed and completed application for Medical Staff appointment and/or request for specific clinical privileges and after receiving a favorable recommendation by the Credentials Committee, following a determination that the applicant meets the essential criteria for membership and/or clinical privileges (as applicable) as required by these Bylaws, an appropriately licensed physician, oral surgeon, or AHP may be granted temporary clinical privileges for up to one hundred twenty (120) days. In exercising such temporary clinical privileges, the applicant shall act under the supervision of the Chairperson(s) of the Department(s) to which he or she is assigned and in accordance with the conditions specified in Section 7.4.2., below.

7.4.1.2 **Care of Specific Patients/Important Patient Care Need.** Upon receipt of a written request for specific temporary clinical privileges, a duly licensed physician, oral surgeon, or AHP of documented competence who is not an applicant for Medical Staff

membership may be granted temporary clinical privileges for the care of one or more specific patients. Such temporary clinical privileges shall only be granted under extraordinary circumstances, may be limited by the Hospital President to a specified number of patients, and shall be exercised in accordance with the conditions specified in Section 7.4.2., below.

7.4.1.3 Locum Tenens. As an extension of important patient care need, upon receipt of a written request for locum tenens clinical privileges, a duly licensed physician, oral surgeon, or AHP of documented competence who will serve as a locum tenens for a Medical Staff member or other clinically privileged practitioner, and who is on the medical staff of and/or clinically privileged at another Medicare-participating hospital may, without applying for Medical Staff membership or clinical privileges at the Hospital, be granted locum tenens clinical privileges for an initial period of sixty (60) days. Such temporary clinical privileges may be renewed for a successive period of up to sixty (60) days, but not to exceed his or her period of service as locum tenens. The temporary privileges shall be limited to treatment of the patients of the practitioner for whom he or she is serving as locum tenens and shall be exercised in accordance with the conditions specified in Section 7.4.2., below. He or she shall not be entitled to admit his or her own patients to the Hospital.

7.4.2 Conditions. In addition to the foregoing, any individual seeking temporary clinical privileges at the Hospital must have his or her licensure, qualifications, and competency appropriately verified, and upon review and consideration of the same, must be recommended for temporary clinical privileges by the applicable Department Chairperson(s) and the Chief of Staff. Special requirements of consultation and reporting may be imposed by the Department Chairperson responsible for supervision of a practitioner granted temporary clinical privileges. Before temporary clinical privileges are granted, the subject practitioner must acknowledge in writing that he or she has received, or has been given access to, and has read the Medical Staff Bylaws and the Hospital's Corporate Compliance Plan, and that he or she agrees to be bound by the terms thereof in all matters relating to temporary clinical privileges.

7.4.3 Restriction, Suspension, and Termination. On the discovery of any information or the occurrence of any event of a nature which raises (in the complete discretion of the Hospital President) questions or concerns regarding a practitioner's professional qualifications, professional conduct, or ability to appropriately or safely exercise any or all of the temporary clinical privileges granted, temporary clinical privileges may be summarily restricted, suspended, or terminated by the Hospital President (or designee), upon recommendation of the Chief of Staff (or designee) and applicable Department Chairperson(s) (or designee(s)). In the event of such restriction, suspension, or termination, the

practitioner's patients then in the Hospital shall be assigned to a Medical Staff member(s) by the applicable Department Chairperson(s). The wishes of patients shall be considered, where feasible, in choosing a substitute practitioner. The substitute practitioner(s) shall have the right to refuse to accept such patient assignments, in which case the Chairperson(s) shall assign the patients to another substitute practitioner(s).

7.4.4 Rights of a Practitioner with Temporary Clinical Privileges. By applying for temporary clinical privileges, all practitioners acknowledge the expected short-term nature of such status and that such status does not confirm appointment, or an expectation of appointment, to the Medical Staff. Accordingly, notwithstanding any provision in the Medical Staff Bylaws to the contrary, **all such practitioners expressly agree that the practitioner shall not be entitled to the procedural rights afforded by the Fair Hearing Manual in the event: a request for temporary clinical privileges is refused or denied, or (if such temporary privileges are granted) all or any portion of the temporary clinical privileges are summarily restricted, suspended, or terminated.**

7.4.5 Emergency Clinical Privileges. For the purpose of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or bystander or in which the life of a patient or bystander is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling of any consultation necessary or desirable, regardless of his or her Department, Medical Staff status, or clinical privileges. The practitioner shall make every reasonable effort to communicate promptly with the appropriate individuals concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available, and once the emergency has passed or assistance has been made available, shall defer to the appropriate Department Chairperson with respect to further care of the patient.

7.5 DISASTER CLINICAL PRIVILEGES

7.5.1 Circumstances. A "disaster," for purposes of this Section 7.5, is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions. Any individual intending to provide services during a disaster event must be granted clinical privileges prior to providing patient care. Disaster privileges are considered temporary in nature.

7.5.2 Conditions.

7.5.2.1 The Hospital President or Chief of Staff, or their respective designees, in circumstances of disaster in which the Hospital's emergency operation plan has been activated, shall have the authority to grant disaster privileges to a physician, oral surgeon, or

AHP who is not a member of the Medical Staff subject to the process and conditions set forth in this Section.

7.5.2.2 Decisions regarding the granting of disaster privileges are made on a case-by-case basis and the Hospital President or Chief of Staff, or their respective designees, are not required to grant privileges to any individual. Prior to granting such privileges, the Hospital President or Chief of Staff, or their respective designees, shall verify information regarding the individual upon presentation of a valid government issued photo identification card and at least one (1) of the following:

- a. A current picture identification card from a health care organization that identifies the practitioner's professional designation;
- b. A current license to practice;
- c. Primary source verification of licensure;
- d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;
- e. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity; or
- f. Confirmation by a practitioner who is currently privileged by the Hospital with personal knowledge regarding the practitioner's ability to act as a licensed independent practitioner during a disaster.

7.5.2.3 Primary source verification of licensure, certification, or registration (if required by Indiana state or federal law in order to practice), as well as verification of credentials and privileges under this Credentialing Manual and the Medical Staff Governance and Organization Manual for granting temporary privileges, shall begin as soon as the disaster is under control, but no later than seventy-two (72) hours. In extraordinary circumstances, primary source verification and/or evaluation for temporary clinical privileges of credentials may occur later than seventy-two (72) hours and as soon as possible. In such case, the Hospital shall document the reasons for any delay, evidence of the practitioner's demonstrated ability to continue to adequate care, treatment and services and evidence of the Hospital's attempt to perform credentialing verification in a timely manner.

7.5.2.4 The MEC or designee will oversee the performance of individuals granted disaster privileges by either direct observation, mentoring or medical record review as may be more fully described in the Hospital's emergency operation plan.

7.5.2.5 The Hospital President or designee will determine within seventy-two (72) hours of each practitioner's arrival whether granted disaster privileges should continue.

7.6 OUTPATIENT DIAGNOSTIC SERVICES

7.6.1 Physicians, oral surgeons, or AHPs with an independent scope of practice who are not members of the Medical Staff or who do not have clinical privileges may order outpatient diagnostic services and outpatient therapeutic services (e.g. physical therapy, occupational therapy or speech therapy) for their patients if it is within their permitted scope of practice to do so. However, all non-affiliated physicians, oral surgeons, and AHPs who desire to order such services must provide evidence of the following qualifications:

7.6.1.1 an unlimited license to practice their specialty; and

7.6.1.2 their ability to participate in Medicare and other federally funded health care programs.

7.6.2 All physicians, oral surgeons, and AHPs who are not members of the Medical Staff or who do not have clinical privileges at the Hospital must also provide accurate and complete contact information at the time any service is ordered. The Hospital or Medical Staff may, at any time and for any reason, refuse to accept a request for an outpatient diagnostic service.

7.7 MEDICO-ADMINISTRATIVE PRIVILEGES

7.7.1 Physicians engaged by the Hospital either full or part-time whose duties are medico-administrative in nature and include Medical Staff clinical responsibilities or functions involving their professional capability as physicians must be members of the Medical Staff. This status shall be achieved utilizing the same procedure as for all other Medical Staff members.

7.7.2 Privileges for medico-administrative physicians shall be delineated in terms of their education, training, competence and character and as well as by the terms of their employment or other agreement.

7.8 SPECIAL CONDITIONS FOR RESIDENTS AND FELLOWS

7.8.1 Residents and fellows in training in the Hospital shall not normally hold membership on the Medical Staff and/or be granted specified clinical privileges. Residents and fellows in training shall be permitted to function clinically in accordance with the written training protocols developed by the CMO or program director in conjunction with the then current residency training program.

7.8.2 Residents or fellows with an Indiana medical license and who intend to practice independently in the Hospital, and who meet all other conditions/requirements for medical staff membership and clinical privileges, shall be required to apply for and receive appropriate medical staff membership and clinical privileges pursuant

to the procedures set forth in this Credentialing Manual and the Medical Staff Bylaws.

7.9 OPTION TO EXPEDITE

7.9.1 Expedited Review. In the event an initial applicant for Medical Staff membership and/or clinical privileges or a practitioner reapplying for Medical Staff membership and/or clinical privileges evidences or has demonstrated the qualifications set forth in Sections 6 and 8 of these Bylaws (as applicable, has submitted a complete application or reapplication form and supporting documents, and otherwise meets all applicable criteria and any applicable regulatory and accrediting agency standards for expedited review, then as **an exception to the general credentialing/recredentialing processes set forth in these Bylaws, the Chairperson of the appropriate Department may opt to initiate an expedited review process by assessing the application or reapplication and forwarding a recommendation directly to the Chairperson of the Credentials Committee, requesting that the application or reapplication be expedited.**

7.9.1.1 The Chairperson of the Credentials Committee may review the application or reapplication and, if recommending the application or reapplication for approval, may forward the application or reapplication directly to the Chief of Staff.

7.9.1.2 The Chief of Staff, in conjunction with at least two (2) members of the MEC (in addition to the Department Chairperson and Credentials Chairperson), may then review the application or reapplication, and if unanimously recommending the application or reapplication for approval, may forward the application or reapplication to the Governing Board, or a designated subcommittee of the Governing Board consisting of at least two (2) voting Governing Board members, to review the application or reapplication and take final action thereon.

7.9.1.3 The review and voting functions contained herein may occur in person or by electronic communication, provided there is a voting record of all such activities. All such expedited review activities and determinations are taken by or on behalf of peer review committees of the Medical Staff and Hospital, are expressly contemplated/permitted by such committees pursuant to these Bylaws, and are intended to increase efficiency, reduce morbidity and mortality, and to improve the quality of patient care provided at the Hospital.

7.9.2 Restrictions and Objections. An applicant or reapplicant is ineligible for the expedited credentialing process if, at the time of appointment or granting of clinical privileges, or if since the time of last reappointment, any of the following has occurred: the applicant or reapplicant submits an incomplete application or reapplication; there is a current challenge or a previously successful challenge to licensure or registration; the applicant or reapplicant has received an involuntary

termination of medical staff membership at another organization; the applicant or reapplicant has received involuntary limitation, reduction, restriction, denial, loss of clinical privileges or is otherwise under current focused peer review or investigation; there has been a final judgment that is adverse to the applicant or reapplicant in a professional liability action; or there is a reasonable concern about the applicant or reapplicant's health status.

7.9.2.1 If the Chairperson of the Department, the Chairperson of the Credentials Committee, the Chief of Staff, or any other member of MEC participating in the expedited review process, or the Governing Board or any voting member designated to participate in the expedited review process does not believe an application or reapplication should be expedited for any reason, the prescribed application and reapplication procedure set forth in these Bylaws shall be followed.

8. ACTIONS AFFECTING MEDICAL STAFF MEMBERS

8.1 PROCEDURE FOR REAPPOINTMENT

8.1.1 When Application is required

8.1.1.1 Reappointment to the Medical Staff shall be for a period of no more than two (2) years with approximately one-fourth (1/4) of the staff reappointed every six (6) months. Any member of the Medical Staff, who at the time of reappointment processing wishes to be considered for a change in his or her Medical Staff category or a change in his or her clinical privileges, shall so indicate on the appropriate application form provided by the President.

8.1.1.2 Prior to the expiration date of the Medical Staff member's appointment, the member shall file an application for reappointment on an application form provided by the President. The form must be completed and submitted to the Medical Staff Services Department. The application shall require the member to furnish information to update his or her file on the information set forth in section 6.3.1. In addition to providing updated information and indicating any change in clinical privileges desired, his or her reappointment to the Medical Staff shall be based upon the additional factors set forth in Section 2 below.

8.1.1.3 Reappointment to the Active Medical Staff with Active Core Privileges requires 25 patient contacts at the Hospital over each two year span commencing with the member's appointment to the Active Staff. Failure to fulfill the requirements of the privileging category shall be reviewed by the Department Chairman and recommendation may be made to change the privileging category or the specified privileges requested. Any such reduction shall not be deemed a professional review action or disciplinary action of any kind, and shall not give rise to any hearing or appeal rights.

8.1.1.4 Clinical Privileges after Age 70

EGH MEDICAL STAFF BYLAWS

- a. In conjunction with their biennial reappointment, at the age of 70, Medical Staff or Allied Health members holding clinical privileges shall complete an examination that reviews both their health status and ability to exercise the privileges requested, from a physician of their choice.
- b. The Credentials Committee shall first assess the applicant's professional qualifications based on the reappointment factors. If the Credentials Committee determines that the individual appears to be professionally qualified for reappointment and continued privileges, it shall make a conditional recommendation to that effect.
- c. The examining physician, mutually acceptable to the applicant and the Credentials Committee, shall perform a physical examination and must indicate whether or not the physician has any physical or mental problem that may interfere with the safe and effective provision of care permitted under the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively in a hospital setting. The written report shall be provided directly to the Committee on an approved form (Appendix A) and submitted by the date requested by the Credentials Committee. The examining physician shall be available to discuss any questions or concerns that the Committee may have.
- d. The examining physician shall identify any accommodations that would be necessary to permit safe practice, discharge of responsibilities and effective functioning. The Credentials Committee and Executive Committee, in conjunction with Hospital management, will determine whether the accommodation(s) would predictably and reasonably afford discharge of responsibilities and effective functioning, based on all of the circumstances. If affirmed, the individual will be reappointed for one year and annually thereafter.
- e. In the event that there is no possible accommodation, or an accommodation would not be appropriate and/or reasonable, the individual will be notified that he/she is ineligible for renewed clinical privileges. While this determination would not entitle the individual to request a hearing, the individual may meet with the MEC upon request.

8.1.1.5 Reappointment to the Courtesy Staff category requires member to verify active staff status at their primary facility, demonstrate competence and demonstrate that their clinical privileges at the Hospital do not exceed clinical privileges at their primary facility. Volume at the member's primary facility, or facilities, must be greater than 55% (fifty-five percent) of the member's Hospital

patient contact volume. If a physician cannot confirm Active status at his or her primary facility, he or she will be required to change to Active status at the Hospital. Commencing with the member's appointment or reappointment to the Courtesy Staff category, failure to admit or care for at least 25 patients each two year period shall cause the member's clinical privileges to be reviewed by the department chairman and recommendation may be made to have the Courtesy Staff Member submit patient care documentation from his or her primary facility for review. Lack of documentation may result in the denial of renewal for some or all of the clinical privileges. Courtesy Staff members who admit or attend to more than 50 patients in two years may trigger review by the MEC for recommendation to a more appropriate staff category. Medical Staff recommended for change to another category as a result of this review, may request an exception by the MEC.

8.1.1.6 Reappointment and Competency for Physicians requesting Active Core privileges with Low Patient Contact Data: Medical Staff members with Active Core Privileges who have been identified to have had less than twenty-five (25) patient contacts at the time of reappointment may be asked to demonstrate competence by providing the following: Physicians will be asked to provide volume and procedure data (including a list of procedures) from other hospitals and/or facilities; any CME obtained in the appointment period; and two peer references from other physicians, who can attest to their clinical skills and competence. Reappointment of a "Low Volume Provider" will follow individual department requirements according to departmental rules and regulations. A Focused Professional Peer Review will be initiated.

8.1.2 **Factors to be considered. Each recommendation considering the reappointment of a Medical Staff member, or a change in privileges, where applicable, shall be based upon a consideration of the following factors:**

- 8.1.2.1** Such member's professional ethics, competence and clinical judgment in the treatment of patients and his or her physical and mental capacity to treat patients;
- 8.1.2.2** his or her attendance at Medical Staff meetings and participation in staff affairs;
- 8.1.2.3** his or her compliance with Hospital Bylaws and policies, the Medical Staff Bylaws, and any pertinent Rules and Regulations;
- 8.1.2.4** his or her effective and efficient utilization of the Hospital's facilities and resources for his or her patients in the delivery of quality medical care;
- 8.1.2.5** his or her maintenance of timely, accurate and complete medical records;

- 8.1.2.6 his or her patterns of care, as demonstrated by reviews conducted by committees, such as utilization review, infection control, tissue, medical records, pharmacy/therapeutics, patient care evaluation and peer review organizations;
 - 8.1.2.7 his or her continuing to keep abreast of current professional theory and practice in order to maintain appointment to the Medical Staff or retention of clinical privileges; and,
 - 8.1.2.8 his or her ongoing compliance with applicable statutes and regulations governing his or her professional conduct and competent practice of medicine.
 - 8.1.2.9 his or her criminal background check may be requested at reappointment.
- 8.1.3 Department Procedures.**
- 8.1.3.1 Medical Staff members who are due for reappointment will be notified by the President or his designee. Members shall have sixty (60) days from notification to complete the application for reappointment. Failure to return the application for reappointment to the President (or the Chairman of the Credentials Committee) within such sixty (60) days shall result in an automatic suspension of privileges, subject to the approval of the President with concurrence of the Chief of Staff. Such suspension shall remain in force until the application for reappointment is received. These documents shall then be transmitted by the President to the chairman of each department for evaluation and recommendation.
 - 8.1.3.2 Within thirty (30) days of receipt of the completed application the chairman of the department shall transmit to the Credentials Committee individual recommendations for reappointment. If the recommendation includes a change in Medical Staff category or clinical privileges, the reason for such changes shall be documented.
- 8.1.4 Credentials Committee Procedure.**
- 8.1.4.1 The Credentials Committee, after receiving recommendations from the chairman of each department shall review all pertinent information available, including all information provided from other committees of the Medical Staff and from Hospital management and from the National Practitioner Data Bank, for the purpose of determining its recommendations for staff appointment, for staff category, and for the granting of clinical privileges, for the ensuing appointment period.
 - 8.1.4.2 When deemed appropriate by the Credentials Committee, the Committee may require that a Medical Staff member procure an impartial physical or mental examination by a practitioner selected by the Credentials Committee either as part of the reapplication process or during the appointment period to aid the Credentials

Committee in determining whether clinical privileges should be granted or continued, and such results shall be made available for the Committee's consideration. Failure of the Medical Staff member to procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary relinquishment of the Medical Staff privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon, if necessary.

8.1.4.3 The Credentials Committee shall prepare a list of Medical Staff members recommended for reappointment without change in staff category and clinical privileges. Recommendations for non-reappointment and for changes in category or privileges, with explanation, shall be handled individually. The list shall be considered a reapplication to the Hospital by each member on the list for reappointment to the Medical Staff and for clinical privileges for the ensuing appointment period.

8.1.4.4 The Credentials Committee shall transmit its report and recommendations to the MEC in sufficient time for the MEC to consider the report at its next regularly scheduled meeting.

8.1.5 Meeting With Affected Staff Member. If during the processing of a Medical Staff member's reappointment it becomes apparent to the Credentials Committee, or the MEC that either committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges or reduce clinical privileges of any staff member, the chairman of the Credentials Committee or MEC shall notify the member of the general tenor of the possible recommendation and ask him/her if he or she desires to meet with the committee prior to any final recommendation. At such meeting, the affected member shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to a hearing shall apply. However, minutes of the discussion held during the meeting shall be kept and shall be considered peer review materials. The committee shall indicate as part of its report to the Board whether such a meeting occurred. If requested, the minutes of the discussion shall be made available to the Board in its capacity as a peer review committee.

8.1.6 MEC Procedure.

8.1.6.1 At least fourteen (14) days prior to a regular scheduled Board meeting, the MEC shall make written recommendations to the Board, through the President, concerning the reappointment, clinical privileges and, where applicable, change in staff category of each staff member.

8.1.6.2 Where non-reappointment or non-promotion or a reduction in clinical privileges is recommended, the reasons for such recommendation shall be stated and documented and included in the report.

8.1.7 Procedure Thereafter.

8.1.7.1 Any adverse recommendation as that term is defined in the Medical Staff Fair Hearing Plan shall entitle the affected member to the procedural rights provided for in Section 9 herein and more fully described in the Medical Staff Fair Hearing Plan. The President shall then promptly notify the staff member of the recommendation by certified mail, return receipt requested according to the procedures set forth in Section 2.2 of the Fair Hearing Plan. The recommendation shall not be forwarded to the Board until the applicant has exercised or has been deemed to have waived his or her right to a hearing as more fully set forth in the Fair Hearing Plan after which the Board shall be given the MEC's final recommendation and shall act on it.

8.2 PROCEDURES FOR REQUESTING INCREASE IN CLINICAL PRIVILEGES

8.2.1 Application for Increased Clinical Privileges. Whenever, during the term of his or her appointment to the Medical Staff, a member or other practitioner desires to have any change in his or her clinical privileges considered, he or she shall apply in writing to the President on an appropriate form. The application shall state in detail the specific additional clinical privileges desired and the applicant's relevant recent training and experience which justifies increased privileges. This application will be transmitted by the President to the Credentials Committee and by it to the appropriate department. Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the time of appointment or as a part of the reappointment application if the request is made at that time.

8.2.2 Factors to be considered. Increase of clinical privileges shall be based upon relevant recent training, the direct observation of patient care provided, review of the records of patients treated in this or, where available, other hospitals and review of all other records and information from applicable departments of the Medical Staff which evaluate the member or practitioners participation in the delivery of medical care that justify increased privileges. The consideration of such increased privileges may carry with it such supervision or consultation for such period of time as thought necessary.

8.3 PERFORMANCE IMPROVEMENT AND QUALITY OF CARE REVIEW

8.3.1 Procedure

8.3.1.1 When reliable information indicates that any Medical Staff member or AHP is considered not to meet the applicable standard of care established by the Medical Staff, to be disruptive to the operations of the Hospital and delivery of quality medical care, to violate Hospital or Medical Staff policies, or that a review of the actions or

quality of care provided by such Member may be necessary or advisable, any member of the Medical Staff may request that a quality of care review be considered regarding such Member. All requests for quality of care review shall be in writing, shall be made to the Hospital's President, the Chief of the Medical Staff, or the Chairman of the Medical Staff Quality Improvement Committee, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

8.3.1.2 Whenever the quality of care review, if based on competence or professional conduct, could result in the revocation, reduction or suspension of Medical Staff membership or clinical privileges, the Chief of Staff shall initiate an investigation as soon as practicable to be conducted by either the MEC or an Ad Hoc Investigating Committee to investigate the matter.

8.3.1.3 Within thirty (30) days of initiating an investigation, the MEC or Ad Hoc Investigating Committee shall prepare a report of its investigation to the MEC. Prior to the making of such report, the practitioner for whom a quality of care review has been requested shall have an opportunity for an interview with the MEC or Ad Hoc Investigating Committee, as applicable. At such interview, s/he shall be informed of the general nature of the concerns raised regarding him/her, 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 rules provided in these Bylaws or related Fair Hearing Plan with respect to hearings shall apply hereto. A record of such interview shall be made by the Ad Hoc Investigating Committee and included with its report to the MEC or Ad Hoc Investigating Committee's report may include a recommendation for corrective action as the committee determines is appropriate. Regardless of the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including the investigative process.

8.3.1.4 Within thirty (30) days of its receipt of the Ad Hoc Investigating Committee's Report, the Medical Executive Committee shall 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; within its authority; 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 sustained; or recommend to the Board that the practitioner's staff membership be suspended or revoked.

8.3.1.5 Except as otherwise provided in these Bylaws, any recommendation by the Medical Executive Committee that would result in an adverse action or decision as provided for in the Medical Staff Bylaws Fair Hearing Plan, may entitle the affected practitioner to certain hearing procedural rights provided in the Fair Hearing Plan. Certain actions that if based on competence or professional conduct, including letters of admonition, warning or reprimand, but do not result in a restriction of clinical privileges do not give rise to hearing rights.

8.3.2 Summary Suspension

8.3.2.1 Whenever there is a good faith belief that the conduct or activities of a 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 the failure to take prompt action may result in imminent danger to the life, health, or safety of any such person, any two (2) of the following persons in their capacity as members or Personnel of a Peer Review Committee shall have the authority to summarily suspend the appointment of such Practitioner to the Medical Staff and/or to summarily suspend or restrict all or any portion of his or her Clinical Privileges: the Chief of Staff, Chairman of the Credentials Committee, Chairman of a Department, Chairman of Medical Staff Quality Improvement Committee, or President. A summary suspension shall become effective immediately upon imposition. The reasons for the suspension shall promptly thereafter be stated in writing and be given to the practitioner in the same manner as other requests for quality of care review. Such a suspension shall be for the purpose of investigation only and shall not imply any final finding of responsibility for the situation causing the suspension.

8.3.2.2 Summary suspensions may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary suspension, the practitioner's patients, if not assumed by the Practitioner's Group, shall be promptly assigned to another Medical Staff member by the Department Chairperson or by the Chief of the Medical Staff, considering where feasible, the wishes of the patient in the choice of a substitute.

8.3.2.3 During the summary suspension, the Medical Executive Committee shall conduct an investigation to determine the need for a recommendation for further action. As soon as possible, but not more than fourteen (14) Days after such summary suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. The Medical Executive Committee, in its sole discretion, may request the

practitioner to attend such meeting and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, though in no event shall any meeting of the Medical Executive Committee, with or without the practitioner, constitute a "hearing" within the meaning of the Fair Hearing Plan, nor shall any procedural rules apply.

8.3.2.4 During the summary suspension, the Medical Executive Committee may continue, modify, or terminate the summary suspension. If the 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 or a report to the National Practitioner Data Bank.

8.3.2.5 If the Medical Executive Committee fails to terminate or determines to continue the summary suspension beyond fourteen (14) days, or recommends other adverse action, the practitioner shall be given a notice with an explanation of such determination or recommendation consistent with Section 2.2 of the Fair Hearing Plan.

8.3.3 Automatic Suspension

8.3.3.1 Any suspension of a practitioner's license to practice his/her profession by his/her licensing board shall automatically suspend the practitioner's clinical privileges for the same period of time. Any such suspension shall be submitted to the Medical Executive Committee. Upon reinstatement of medical license, the suspension shall not be lifted until the Medical Executive Committee determines whether to initiate its own corrective action.

8.3.3.2 Any notification that a practitioner no longer qualifies as a health care provider under the Indiana Medical Malpractice Action (IC 34-18) shall automatically suspend any such practitioner's clinical privileges in the Hospital until such qualification under the Act is reestablished.

8.3.3.3 Such practitioners shall be notified of such actions and shall be allowed to appear before the Executive Committee to explain and to petition for reinstatement.

8.3.4 Other Actions Concerning Staff Members

8.3.4.1 A practitioner's patient's charts shall be deemed delinquent if not completed within a specified time after discharge of a patient as established in the rules and regulations of the Medical Staff. The Medical Records Department shall issue an immediate notice to each practitioner who has one (1) or more delinquent charts. The MEC or the Chief of Staff shall impose such discipline as is permitted by the rules and regulations upon practitioners whose

charts remain delinquent beyond the time limits set out in the rules and regulations.

8.3.4.2 Failure to attend meetings as required by these Bylaws or failure to pay Medical Staff dues as required, may be grounds for termination of Medical Staff membership as determined by the MEC pursuant to Section 3.5.2.1 herein.

8.4 PROCEDURE FOR LEAVE OF ABSENCE. Members of the Medical Staff may, for good cause, be granted leaves of absence for a definitely stated period of time by the Board. Under no circumstances, however, shall a leave of absence be granted because of the termination or suspension of a practitioner's license to practice his or her profession or because the practitioner is no longer qualified under Indiana's Medical Malpractice Act (I.C. 34-18 *et seq.*).

8.4.1 Procedure for leave of absence. Individuals appointed to the medical staff may request a leave of absence by submitting a written request to the Chair of the Department in which the individual has his or her primary clinical privileges. The request must state the beginning and ending dates of the leave, which shall not exceed twelve (12) months, and the reasons for the leave, such as military duty, additional training, family matters (which includes maternity/ paternity leave), or personal health condition. Absence from medical staff and patient care responsibilities for longer than 60 days shall require an individual to request a leave of absence. If such leave is due to health reasons such as injury or illness, the practitioner must request a Medical Leave of Absence, and must include a physician's statement as to the need for the leave.

8.4.2 The Department Chair shall transmit the request together with his or her recommendation to the MEC, which shall make a report and a recommendation and transmit it to the President for action by the Board. The Board delegates to the President the authority to make determinations in connection with requests for leaves of absence, provided that the Board reserves the right to make final determinations, in its discretion. In determining whether to grant a request, the President shall consult with the Chief of Staff and applicable department chair, and use his best efforts to make a determination within thirty (30) days of the receipt of the written request and of any clarifying information that the President may request.

8.4.3 During a Medical Leave of Absence, the practitioner shall be exempt from completion of medical records, but shall be required to complete any outstanding medical records as soon as medically possible; shall be exempt from any and all patient care responsibilities, including ED and any other call; shall be excused from any and all Medical Staff responsibilities; and, shall not be exempt from payment of Medical Staff dues.

8.4.4 During a non-Medical Leave of Absence, the practitioner shall be exempt from completion of medical records during the leave, but shall be required to complete all medical records prior to the leave; shall be exempt from any and all patient care responsibilities, including ED and any other call; shall be excused from any

and all Medical Staff responsibilities; and, shall not be exempt from payment of Medical Staff dues.

- 8.4.5** No later than thirty (30) days prior to the conclusion of the leave of absence, the individual must request reinstatement by providing to the President a written statement sufficient to demonstrate current competency and all other appropriate qualifications during the leave of absence. The President shall refer the matter to the MEC for a recommendation. The individual bears the burden of providing the sufficient information and documentation. The individual shall provide any other information requested by the President or the MEC, including executing any releases that may be necessary to cause third parties, including the individual's physician, to respond to any requests for information or clarification.
- 8.4.6** If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a Hospital practice and safely exercising the clinical privileges requested.
- 8.4.7** The President shall consider the recommendation of the MEC and may approve reinstatement to either the same or a different staff category and may limit or modify the clinical privileges to be extended to the individual upon reinstatement, or impose conditions for the individual's practice deemed reasonably necessary for patient safety or the effective operation of the Hospital. The parties may refer this to a committee such as the Credentials Committee at their discretion. In the event that the President determines that denial of reinstatement or modifications or conditions would require a report to the National Practitioner Data Bank, the individual shall be given written notice and the opportunity to request a hearing within thirty (30) days.
- 8.4.8** Failure to return or request an extension at the end of a Leave of Absence shall constitute a voluntary resignation from the Medical Staff. Absence for longer than one (1) year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is requested in writing at least thirty (30) days prior to the end of the leave and granted by the Board. Extensions will be considered only in extraordinary cases of hardship and when extension of a leave is found to be in the best interest of the Hospital. Neither voluntary resignation nor automatic relinquishment shall give rise to hearing or appeal rights.

8.5 FAIR HEARING PLAN. The provisions under this section 8 concerning hearing and appeal rights under Section 9 of these Bylaws should be read in concert with the Fair Hearing Plan attached hereto as Exhibit "1." To the extent the provisions under this section 8 are irreconcilable or in conflict with the provisions of the Fair Hearing Plan, the provisions of the Fair Hearing Plan shall take precedence.

9. HEARING AND APPELLATE REVIEW PROCEDURE. The hearing and appellate review procedures anticipated by, and provided in, these Bylaws are set forth in the Medical Staff Fair Hearing Plan attached hereto and made a part hereof as Exhibit "1."

10. RULES AND REGULATIONS OF THE MEDICAL STAFF

- 10.1** The Medical Staff, as well as the Board, shall adopt rules and regulations as may be necessary to implement more specifically the general principles of conduct found in these Bylaws. Rules and regulations shall set standards of practice that are to be required of each practitioner in the Hospital and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and regulations shall have the same force and effect as the Bylaws.
- 10.2** Particular rules and regulations may be amended, repealed or added by vote of the MEC at any regular or special meeting, provided that copies of the proposed amendments, additions or repeals are posted on the Medical Staff bulletin board and made available to all members of the MEC fifteen (15) days before being voted on, and further provided, that all written comments of staff members on the proposed changes be brought to the attention of the MEC before the change is voted upon. Changes in the rules and regulations shall become effective only when approved by the Board. Board approval of Medical Staff rules and regulations shall not be unreasonably withheld.
- 10.3** Rules and regulations may also be amended, repealed or added by the Medical Staff at a regular meeting or special meeting called for that purpose provided that the procedure used in amending the Medical Staff Bylaws is followed. All such changes shall become effective only when approved by the Board. Board approval of Medical Staff rules and regulations shall not be unreasonably withheld.
- 11. IMMUNITY FROM LIABILITY.** The following shall be express conditions to any Practitioner's application for Medical Staff membership or exercise of clinical privileges at the Hospital.
- 11.1** That any act, communications, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.
- 11.2** That such privilege shall extend to members of the Medical Staff and to its Board of Directors, Hospital administration, including its President, and to third parties who supply information to any of the foregoing authorized, to receive, release or act upon the same or otherwise serve as personnel of a peer review committee as that term is defined. For the purpose of this Article XI, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Board of Directors or of the Medical Staff.
- 11.3** That there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure, even where the information involved would otherwise be deemed privileged.
- 11.4** That such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to: (1) applications for appointment or clinical privileges, (2) periodic reappraisals for reappointment or clinical privileges, (3) actions related to quality of care reviews, including summary suspension, (4) hearings and appellate reviews, (5) medical care evaluations, (6) utilization reviews, (7) claims reviews, (8) malpractice loss prevention, and (9) other Hospital, service or committee activities related to quality patient care and inter-professional conduct.

11.5 That the acts, communications, reports, recommendations and disclosures referred to in this Article XI, may relate to a physician's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly have an effect on patient care.

11.6 That in furtherance of the foregoing, each physician shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this section 11, in favor of the individuals and organizations specified in Section 2, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the law of this state.

12. ALLIED HEALTH CARE PROVIDERS AND PHYSICIAN EXTENDERS

12.1 ALLIED HEALTH CARE PROVIDERS

12.1.1 Qualifications. Such persons shall be governed by these Bylaws and their applications shall be submitted on forms provided by the President and processed pursuant to the procedures set forth in section 6 of these Bylaws and their reapplications shall be processed pursuant to the procedures set forth in section 8 of these Bylaws. AHPs shall not be members of the Medical Staff, shall have no vote in Medical Staff elections or deliberations, may not admit patients, with the exception of podiatrists and dentists as addressed herein, and are not required to attend Medical Staff meetings or to serve on any committees. Because Elkhart General Hospital is organized and functions under a theory of medicine which is mutually intelligible by allopathic doctors, doctors of osteopathy, dentists, podiatrists and oral surgeons, but which is not congruent with the theory of chiropractic or acupuncture, chiropractors and acupuncturists shall not be considered for Medical Staff membership or for clinical privileges as AHPs.

12.1.2 Eligibility. Those persons defined as AHPs herein or others as deemed appropriate by the Governing Board who are licensed or certified to practice in the State of Indiana, who can document their education, training, experience and demonstrated competence, their adherence to the ethics of their professions, their good reputations, their ability to work with others in the provision of patient care, their ability and willingness to make efficient use of Hospital facilities so as not to jeopardize the financial stability of the institution, and their good health, with sufficient adequacy to assure the Medical Staff and the Board that any patient treated by them in the Hospital will be given an appropriate level of medical care, may qualify for privileges as an AHP. No such AHP shall be entitled to exercise privileges as an AHP in the Hospital merely by virtue of the fact that he or she is duly licensed to practice his or her profession in this or in any other state, or that he or she is a member of any professional organization, or that he or she had in the past or presently has, any such privileges at this or another Hospital. No decisions on appointment as an AHP or privileges will be influenced by an applicant's race, religion, sex, national origin, or disability.

12.1.3 Obligations. Application for and/or acceptance of privileges as an AHP shall constitute the applicant's agreement that he or she will strictly abide by the code of ethics which governs his or her professional organization and by all of the

terms and provisions of these Bylaws as they now exist or hereafter shall be amended.

- 12.1.4** Hold-Harmless Agreement. Application for and/or acceptance of privileges as an AHP shall constitute an agreement to authorize the members of the Medical Staff as agents of the Board to inquire and to gather any and all information concerning the applicant and/or provider with regard to his or her qualifications to exercise privileges in the Hospital, shall constitute an authorization to any and all persons and organizations to release such information to the Board, its agents and/or employees and shall constitute an agreement to release and hold harmless all persons, organizations, including the Board, its agents and employees and all others who participate in good faith in providing such information regarding the applicant and/or staff member.
- 12.1.5** Allied Health Care Provider. An AHP desiring Hospital privileges shall, with his or her application, furnish proof of qualification as a health care provider under the provisions of the Indiana Medical Malpractice Act (I.C. 34-18 *et seq.*); or if unable to qualify as a provider under the Act, he or she shall furnish proof of insurance at least equal to or exceeding the minimum limits provided for thereunder, and shall agree to remain so qualified or insured as a condition of eligibility for privileges hereunder. Any notification that an AHP no longer qualifies under the Indiana Medical Malpractice Act (I.C. 34-18 *et seq.*) as required under this sub-section, or no longer has the insurance coverage required under this sub-section, shall automatically suspend any such provider's privileges in the Hospital until the President is provided with proof that the provider is in compliance with such requirements. The AHP shall also be deemed to have agreed to be responsible for all of his acts while attending patients in the Hospital.
- 12.1.6** Advanced Practice Nurse Privileges. According to Indiana Legislation Code, APN means a Nurse Practitioner (NP), Nurse Midwife (CNM), or Clinical Nurse Specialist (CNS). The scope and extent of privileges (such as the ability to write diagnostic and therapeutic orders) that each APN may perform shall be specifically delineated according to the individual's collaborative agreement with a sponsoring physician and as directed by Indiana State Law. Once a sponsoring physician enters into an agreement with an APN, requests for privileges will be considered and processed in the same manner as all other medical privileges and surgical procedure privileges. According to Indiana State Law, the delegation of medical tasks is appropriate to the APN's level of competence and within the supervising physician's scope of practice. Medical care performed by APNs shall be under the direct supervision of a physician sponsor and under the overall supervision of the Department Quality Improvement Committee to which the sponsoring physician belongs.
- 12.1.7** Physician Assistant (PA) Privileges. The scope and extent of privileges (such as the ability to write diagnostic and therapeutic orders) that each PA may perform shall be specifically delineated according to the individual's collaborative agreement with a sponsoring physician and as directed by Indiana State Law. Once a sponsoring physician enters into an agreement with a PA, requests for

privileges will be considered and processed in the same manner as all other medical privileges and surgical procedure privileges. According to Indiana State Law, the delegation of medical tasks is appropriate to the PA's level of competence and within the supervising physician's scope of practice. Medical care performed by PAs shall be under the direct and immediate supervision of a physician sponsor, as required by Indiana State Law, and under the overall supervision of the Department Quality Improvement Committee to which the sponsoring physician belongs.

- 12.1.8** Diagnostic and Therapeutic Orders written by APNs and PAs. Diagnostic and Therapeutic Orders may be written by APNs and PAs within the authority of their clinical privileges and collaborative agreements with a sponsoring physician, and as directed by Indiana State Law. APNs and PAs working under the authority of their license, prescriptive authority, and scope of practice may be granted privileges to write orders for services without a co-signature. APNs and PAs may not order physical therapy services or home care services and are still required to have a medical staff sponsor.
- 12.1.9** Medical Staff Sponsors. Because no AHP may admit or co-admit patients to the Hospital, with the exception of podiatrists, dentists, and midwives, as addressed herein, and no AHP can provide services to a patient in the Hospital without an agreement with a sponsoring physician applications for privileges as an AHP must contain the name of at least one Medical Staff Member who has agreed to make use of the services of the applicant as an AHP and who has agreed to supervise the quality of care of that AHP within the Hospital. A physician sponsor, by signing such an application, is not obligated to request the services of that AHP thereafter but is obligated to supervise and review the quality of care being provided by that allied health care provider within the Hospital. Any reapplication by an AHP must be accompanied by a review of the past year's performance by that health care provider written by the Medical Staff sponsor and any other Medical Staff members who have requested the services of the AHP. The employing and/or sponsoring physician will sign for the competency of their extender or nurse practitioner and review a list of privileges.
- 12.1.10** Reapplication. Any reapplication by an AHP must be accompanied by an attestation of a performance review of cases performed by the health care provider in accordance with the state license requirements and the collaborative agreement (during the specified period) by that health care provider. The review and attestation should be written by the medical staff sponsor who will also sign for the competency of his or her APN or PA and review a list of privileges.
- 12.1.11** Dental Privileges. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical procedures. Surgical procedures performed by dentists shall be under the overall supervision of the Surgery Committee. All dental patients shall receive the same basic medical appraisal on admission as patients admitted to other surgical services. A physician Member of the Medical Staff shall be responsible for the initial history and physical examination and assessment of the

patient's medical condition at the time of admission and shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. Dentists may not admit patients without the concurrence and co-admission of a physician member of the medical Staff. The dentist shall be responsible for recording on the patient's chart an admitting dental history; a dental physical examination with a detailed description of the examination and preoperative diagnosis; a complete operative report describing the procedure, reason, results of specific actions, and the postoperative diagnosis; progress notes, and a dental discharge summary statement.

12.1.12 Podiatric Privileges. The scope and extent of the surgical procedures that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by podiatrists shall be under the overall supervision of the Surgery Department. All podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. Podiatrists may not admit patients without the concurrence and co-admission of the patient by a physician Member of the Medical Staff. The podiatrist shall be responsible for recording on the patient's chart an admitting podiatric history; a podiatric physical examination with a detailed description of the examination and preoperative diagnosis; a complete operative report describing the procedure, reason, results of specific actions, and the postoperative diagnosis; progress notes, and a podiatric discharge summary statement.

12.1.13 Midwife Privileges. The scope and extent of the surgical procedures that each midwife may perform shall be specifically delineated and granted in the same manner as all other obstetrical privileges. Obstetrical procedures performed by midwives shall be under the overall supervision of the Surgery Department. All midwife patients shall receive the same basic medical appraisal as patients admitted to other surgical services. Midwives may not admit patients without the concurrence and co-admission of the patient by a physician Member of the Medical Staff. The midwife shall be responsible for recording on the patient's chart an admitting obstetric history; an obstetric physical examination with a detailed description of the examination and preoperative diagnosis; a complete operative report describing the procedure, reason, results of specific actions, and the postoperative diagnosis; progress notes, and an obstetric discharge summary statement.

12.1.14 Low Volume. Podiatrists, Dentists, APNs and PAs who have been identified to have low patient contacts at the time of reappointment will be asked to demonstrate competence by providing two (2) letters of reference from other physicians that can attest to their clinical skills and competence AND the Practitioner's Physician sponsor letter (as applicable). Departmental Rules and Regulations regarding the "Low Volume Provider" will apply and a Focused Professional Peer Review will be initiated.

12.2 PHYSICIAN EXTENDERS

- 12.2.1** Physician Extenders, as defined herein, shall apply for privileges on forms provided by the Hospital's President and such applications shall be processed pursuant to the procedures set forth in section 6 of these Bylaws. Such forms shall require the submission of information concerning the applicant's education, training, experience, good character, health, ethics and the specific privileges which the Physician Extender is requesting. This form shall also be used when a Physician Extender is reapplying for privileges. A Physician Extender's reapplication for privileges shall be processed pursuant to the procedures set forth in section 8 of these Bylaws. However, except under the circumstances set forth in section 12.2.5 of this section 12 and pursuant to the procedures set forth in said section 12.2.5, no recommendation made by the Credentials Committee or decision by the Board with respect to a Physician Extender's application, reapplication, or privileges shall give rise to any hearing or appeal rights. Physician Extenders shall not be members of the Medical Staff, shall have no vote in Medical Staff elections or deliberations, and are not required to attend Medical Staff meetings or to serve on any committees.
- 12.2.2** The application for privileges as a Physician Extender must contain information from the physician employer/s stating that the physician employer/s shall at all times be responsible for the acts and/or omissions of the Physician Extender within the Hospital. Furthermore, the physician employer shall provide proof that the Physician Extender is expressly included, by name or by reference to the occupation he or she performs for the physician employer, in the professional liability insurance policy of the physician employer; and that such policy is to be in effect until the expiration of the then current Medical Staff year. For Physician Extenders who have been provided privileges, such proof of a Physician Extender's inclusion in a physician employer/s's professional liability insurance policy shall be provided to the Credentials Committee at the beginning of each Medical Staff year. Additionally, each physician employer/s must provide a written statement whereby each physician employer/s agrees that he or she will at all times undertake the supervision of the Physician Extender in the Hospital.
- 12.2.3** The Medical Staff shall establish a delineation of privileges for Physician Extenders and other physician employees. Physician Extenders shall not be considered AHP under these Bylaws.
- 12.2.4** Functions delegated to Physician Extenders shall be based upon their training, experience, and demonstrated competence and judgment. All procedures performed by a Physician Extender will be under the direct supervision of the physician employer who shall be responsible for the care of the patient. The scope and extent of the procedures performed by the Physician Extender shall be limited to specific, delegated acts, tasks, or functions as they relate to the privileges of the physician employer. The procedures performed must be those authorized specifically by the physician employer who assumes responsibility for the validity of the observations and for the proper performance of the procedures. Physician Extenders will not write orders except at the specific direction of the physician employer in which case the Physician Extender will sign

the order with the employer's name per his or her own name. The order must then be countersigned by the physician employer within twenty-four (24) hours.

- 12.2.5 Denial of Privileges.** Whenever the activities or conduct of a Physician Extender are considered by the Chief of Staff, Chairman of the Credentials Committee, Chairman of Medical Staff Quality Review, or the President to be below the standards and criteria established for a Physician Extender, any two of these individuals acting as a Peer Review Committee may summarily suspend the privileges of an Physician Extender. The physician employer shall then be given notice in writing of the effective time and date of the suspension and the reasons for such suspension. The physician employer and/or an or Physician Extender may within five (5) days after the receipt of such notice, request a hearing on the matter before the MEC, but the summary suspension shall remain in effect pending such hearing and a decision by the committee. The physician employer and the Physician Extender shall be given at least three (3) days' written notice of the time and place of the hearing. The hearing shall be conducted informally by the Chairman of the MEC, or in his or her absence by his or her delegate as a professional discussion, and neither the physician employer, the Physician Extender nor the committee shall be represented at the hearing by an attorney. The MEC may modify, terminate, or affirm the action of the Medical Staff Member or President imposing the summary suspension. The physician employer or the Physician Extender shall be given written notice of the determination of the MEC.
- 12.2.6** The review by the MEC shall be confined to a review of the matters which were before the individual issuing the summary suspension, but may also include new evidence at the discretion of the members of the MEC. If the MEC believes that the suspension was basically fair and was made upon sufficient evidence, the MEC shall affirm the suspension, and no further appeal may be had. If the MEC feels that the suspension should be modified, the MEC may impose, modify, or reject the suspension without further appeal to the Board of Trustees or otherwise.
- 12.2.7** The physician employer and the Physician Extender shall, in applying for assignment of privileges hereunder, be deemed to have agreed to the provisions herein for discipline and suspension and also to have agreed that it is in the best interest of good patient care that such disciplinary measures be taken without risk of professional liability on the part of any Members of the Medical Staff, the members of its committees, or the officers or employees of the Hospital. Therefore, the application for privileges as a Physician Extender shall contain a statement that all persons acting in granting or withholding privileges or in disciplinary actions shall be absolutely immune from civil liability arising from any acts, reports, communications, or recommendations made thereunder in good faith.
- 12.2.8** If the recommendation of the MEC, concerning an application or re-application for privileges requested by or for a Physician Extender pursuant to section 12.2 is adverse to the applicant or re-applicant, the Physician Employer of an applicant

or re-applicant for privileges as a Physician Extender, may, within five (5) days after the applicant's or re-applicant's receipt of notification of the executive Committee's adverse recommendation, request an informal meeting with the MEC to discuss the MEC's adverse recommendation. Such request shall be in writing and shall be mailed, via certified mail, to the Chairman of the MEC and the President of the Hospital. Upon receipt of such request, the MEC shall schedule a time and place for such informal meeting, which shall take place no later than sixty (60) days after the date of the request for such informal meeting. Unless agreed to by the MEC, the affected applicant or re-applicant shall not attend such meeting, and neither the MEC nor physician employer may be represented by an attorney at the meeting. Following the informal meeting, the MEC may affirm, modify or rescind its original recommendation. Such affirmation, modification or rescission shall be final, and neither the applicant, re-applicant, Physician Extender shall have any right whatsoever to appeal such action by the MEC to the Board or to any other body. Failure of the physician employer to request such a meeting within the requisite five (5) day period shall constitute a waiver of such meeting and the MEC's recommendation shall be final and non-appealable to the Board or any other body.

12.2.9 Low Volume. Physician extenders who have been identified to have low patient contacts at the time of reappointment will be asked to demonstrate competence by providing two (2) letters of reference from physicians that can attest to their clinical skills and competence AND the Extender's Physician sponsor letter (as applicable). Departmental Rules and Regulations regarding the "Low Volume Provider" will apply and a Focused Professional Peer Review will be initiated.

12.3 CORRECTIVE ACTION

12.3.1 No Entitlement to Medical Staff's Fair Hearing Plan. Physician Extenders shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff's Fair Hearing Plan or any other Hospital or Medical Staff policy or document.

12.3.2 Meeting following Denial or Revocation

12.3.2.1 In the event that an AHP, excluding Hospital employees, is not granted Clinical Privileges at the Hospital or whose Clinical Privileges are revoked, the AHP, and when applicable, his or her employing or supervising Member, shall have the right to appear personally before the Credentials Committee to discuss the decision, without attorney present.

12.3.2.2 If the AHP desires to appear before the Credentials Committee, he or she must make such request: a) in writing; and b) within ten (10) days of the decision to deny or revoke Clinical Privileges.

12.3.2.3 Should the AHP request an appearance in a timely manner, the AHP will be informed of the general nature of the information supporting the decision to deny or revoke prior to the scheduled meeting.

- 12.3.2.4 At the meeting, the AHP and, when applicable, his or her employing or supervising Member, shall be invited to discuss the decision.
- 12.3.2.5 Following the meeting, the AHP will be notified in writing within ten (10) days of the Credentials Committee's final decision, whether favorable or unfavorable.

13. HISTORY AND PHYSICAL REQUIREMENTS

13.1 A medical history and physical examination, which is signed or cosigned by a Physician, must be completed and documented for each patient in accordance with the Medical Staff Rules and Regulations, Medical Staff policies, accreditation standards, Indiana state and federal law, and Hospital policies. In all instances, a history and physical exam must be performed and documented within thirty (30) days prior to date of admission or within twenty-four (24) hours after an admission. If a history and physical is performed and documented prior to the date of admission, then a thorough updating entry must be provided within twenty-four (24) hours after the admission, which documents/addresses vital signs, systems stability, any systems or other relevant change, and any other information pertinent to the admission. With respect to surgical patients, in all such cases there must be a history and physical workup in the chart prior to surgery, except in emergencies. If the report has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the admitting physician, which includes vital signs, allergies, and all other appropriate data.

14. RELATED MEDICAL STAFF DOCUMENTS

14.1 ADOPTION OF RELATED DOCUMENTS

14.1.1 In addition to this Bylaws document, the Medical Staff and Board have adopted the following documents that shall, collectively, make up the Medical Staff Bylaws, which exist to support the Medical Staff:

14.1.1.1 The Medical Staff Fair Hearing Plan, which shall specify pertinent hearing and appeal procedures; and

14.1.1.2 The Medical Staff Rules and Regulations, which shall further define certain rights and responsibilities of practitioners related to their professional and clinical activities.

14.2 MEDICAL STAFF BYLAWS ARE NOT A CONTRACT

14.2.1 The Medical Staff Bylaws are intended to create a framework to ensure compliance with pertinent State and Federal law, and accreditation requirements, and to ensure entitlement to all immunities and protections set forth in the pertinent State peer review statutes and the Federal Health Care Quality Improvement Act. These Bylaws are not intended in any fashion to create a legal contract. Accordingly, these Bylaws shall not be interpreted as, nor construed to be, a contract of any kind between the Hospital and the Medical Staff as a whole, or any individual Member, Applicant, or AHP individually, and shall not in any fashion give rise to any type of legal action, claim or proceeding for breach of contract.

14.3 RULES AND REGULATIONS

- 14.3.1** The MEC shall have the authority of the Medical Staff to adopt and amend the Medical Staff Rules and Regulations as may be necessary to carry out the Medical Staff's functions. Any changes to the Rules and Regulations shall become effective when approved by the Board. All Rules and Regulations and amendments under consideration by the MEC must first be communicated to the Medical Staff for review and comment prior to the proposed Rules and Regulations or amendment being adopted and forwarded to the Board for approval. Any Rules and Regulations adopted by the MEC and approved by the Board shall be communicated to the Medical Staff in a timely manner.
- 14.3.2** Rules and Regulations may also be proposed directly to the Board by a majority of the Active Staff. Before submitting to the Board, proposed Rules and Regulations must be brought before the Active Staff by a petition signed by at least ten percent (10%) of the members of the Active Staff. Any proposed Rules and Regulations must be presented to the MEC for review and comment before such Rule and/or Regulation is voted on by the Active Staff. All proposed Rules and Regulations become effective only after approval by the Board.
- 14.3.3** In the event there is a documented need for an urgent amendment to the Rules and Regulations to comply with a pertinent accreditation standard, law, or regulation, the MEC may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notice to the Medical Staff. In such case, the Medical Staff shall be immediately notified by the MEC. Members of the Medical Staff may submit any comments regarding the provisional amendment to the MEC within ten (10) days of receiving notice. The amendment will stand if there is no conflict or dispute. If at least ten percent (10%) of the Active Staff dispute the amendment, a Joint Conference Committee shall be formed, and the matter resolved, pursuant to Section 15, below.

14.4 MEDICAL STAFF POLICIES

- 14.4.1** The MEC, subject to Board approval, may also adopt and amend various policies and procedures to fulfill its obligations and functions as described herein, provided such policies do not conflict with these Bylaws, the Hospital Bylaws, System policies, and applicable accreditation standards, Federal law, or State law. Any Medical Staff policy or procedure that conflicts or is otherwise inconsistent with these documents, standards, or laws shall be considered void and without effect. All policies and policy amendments adopted by the MEC and approved by the Board shall be communicated to the Medical Staff in a timely manner.
- 14.4.2** Policies may also be proposed directly to the Board by a majority of the Active Staff. Before submitting to the Board, proposed policies must be brought before the Active Staff by a petition signed by at least ten percent (10%) of the members of the Active Staff. Any proposed policies must be presented to the MEC for review and comment before such policy is voted on by the Active Staff. All proposed policies and related amendments become effective only after approval by the Board.

15. CONFLICT RESOLUTION

15.1 If a conflict or dispute arises or is reasonably expected to arise between the Medical Staff and MEC regarding the adoption, amendment, or deletion of Bylaws, recommendations to adopt or change Rules and Regulations, policies, or any other issues in dispute between or among the Medical Staff, Board and/or Hospital Administration, the Medical Staff, the MEC, Hospital Administration, and the Board should work collegially to manage the conflict or dispute. All conflict resolution should initially occur through informal steps. An informal approach may include the use of external resources or a Hospital representative trained in conflict management to help facilitate the process. If a resolution cannot be reached through informal means, the matter may be referred to a Joint Conference Committee comprised of either the Medical Staff and Board, or the Medical Staff and MEC, as applicable.

15.1.1 If the conflict is between members of the Medical Staff and the MEC, the disputed matter shall be submitted to a Joint Conference Committee upon a petition signed by at least ten percent (10%) of the Active Staff.

15.2 JOINT CONFERENCE COMMITTEE

15.2.1 Composition

15.2.1.1 If the conflict or dispute is between or among the Medical Staff, Board, and/or Hospital Administration, the Joint Conference Committee shall consist of three (3) members of the Board as selected by the Chairperson of the governing board and three (3) members of the Active Staff as selected by the Chief of Staff. In such event, the Chairperson of the Joint Conference Committee shall be the Chairperson of the Governing Board.

15.2.1.2 If the conflict or dispute is between the Medical Staff and the MEC, the Joint Conference Committee shall consist of the three (3) members of the MEC as selected by the Chief of Staff and three (3) members of the Active Staff as designated by the Active Staff member submitting the petition. In such event, the Chairperson of the Committee shall be the Chief of Staff.

15.2.1.3 The Hospital President shall serve as an ex-officio member of any Joint Conference Committee without vote.

15.2.2 Duties/Voting

15.2.2.1 The Joint Conference Committee shall gather information regarding the conflict, meet to discuss various issues in dispute, and work in good faith to resolve the matter in a manner that protects safety and quality throughout the Hospital. The Joint Conference Committee may take action by majority vote.

16. AMENDMENTS AND PERIODIC REVIEW

16.1 The Medical Staff Bylaws shall be reviewed, minimally, every three years.

16.2 All proposed amendments and restatements to the Medical Staff Bylaws, except the Rules and Regulations, should first be reviewed and recommended by the MEC.

16.2.1 Requests for amendment or restatement may also be recommended by the Active Staff following a written petition signed by at least ten percent (10%) of the Active Staff.

- 16.3** Proposed amendments or restatements may be considered at any regular or special meeting of the Medical Staff (when a quorum is present pursuant to Section 3.6, above) after the proposed amendments have been published for, or otherwise made available to, the Medical Staff at least five (5) days in advance of the meeting where a vote is taken. To be adopted, any such amendments shall require an affirmative vote by those Active Staff members in attendance. Any proposed revisions made to these amendments or restatements adopted at a regular or special meeting of the Medical Staff, and any technical corrections made by the MEC related to reorganization, renumbering, punctuation, spelling or grammar related changes or necessary to comply with law or regulation may be provisionally adopted without publication as is otherwise required under this Section 16. Such proposed amendments or restatements, however, shall be promptly published to the Medical Staff and shall be considered at the next regular or special meeting of the Medical Staff (after the or proposed amendments/restatements have been published for at least five (5) days).
- 16.4** To be adopted, an amendment must receive a two-thirds (2/3) majority of the votes cast by the staff members eligible to vote who are present at the time of such vote and who do vote.
- 16.5** Amendments so adopted shall be effective when approved by the Board and the text of said amendments shall be distributed to all members of the Medical Staff. Board approval of Medical Staff bylaw amendments initiated by the Medical Staff shall not be unreasonably withheld by the Board.
- 17. DUES AND FEES**
- 17.1** All credentialed providers, excepting providers with interim privileges, physicians in training, shall pay annual dues on a calendar year basis and prior to the first day of February on each and every year thereafter.
- 17.2** Credentialing fees for initial applications shall be set by the Board upon recommendation from the MEC. Physicians in training will not be required to pay credentialing fees.
- 18. ADOPTION**
- 18.1** These Bylaws are adopted and made effective when approved by the Board of Directors, superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each and every member of the Medical Staff shall be taken under and pursuant to the requirements of these Bylaws.