

MEDICAL STAFF BYLAWS

Adopted: July 2008

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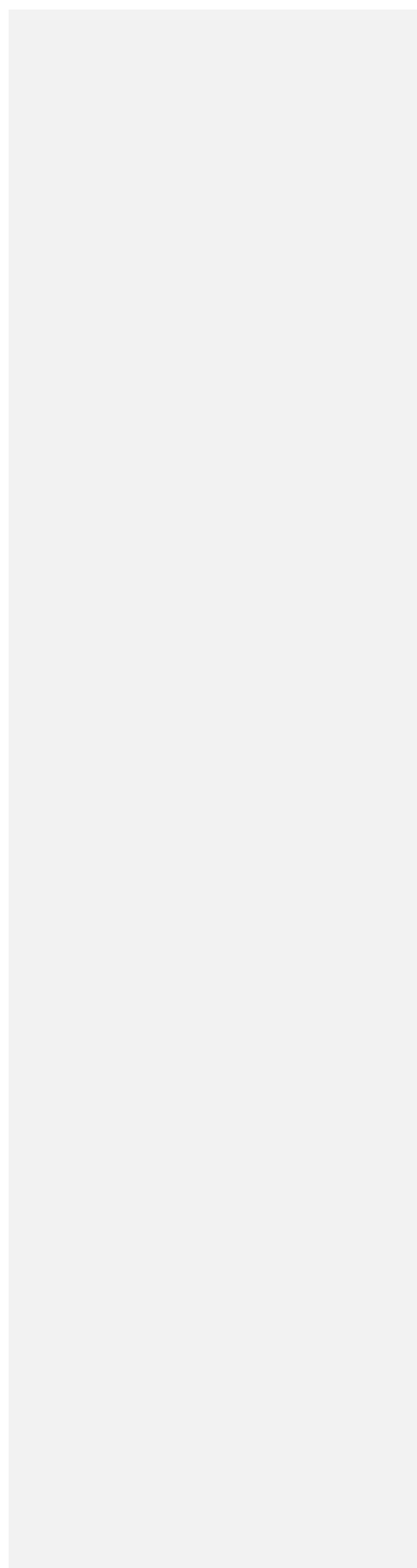
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DEARBORN COUNTY HOSPITAL

MEDICAL STAFF

BYLAWS

PREAMBLE

These Bylaws, which originate with the Medical Staff, are adopted in order to provide for the organization of the Medical Staff of Dearborn County Hospital, the Board of Trustees, and any of their committees or agents in order to promote professional peer review activity designed to establish a harmonious environment in which appropriate standards of medical care may be achieved, constitute themselves as professional review bodies and as "peer review bodies" pursuant to the Health Care Quality Improvement Act of 1986 and Indiana's Peer Review Act, IC 34-4-12.6-1, and as such claim all the rights, privileges, and immunities provided under those acts. In performing Peer Review, the members of the Medical Staff act solely as the agents of the Board of Trustees.

The Medical Staff Bylaws 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 Trustees, and relations with applicants to and members of the Medical Staff.

These Bylaws, when accepted by the Board of Trustees, create a system of mutual rights and responsibilities between members of the Medical Staff and the Hospital, but are not to be considered a contract.

DEFINITIONS

1. **ADVERSE ACTION** means any action reducing, restricting, suspending, revoking, denying or failing to renew clinical privileges or membership on the Medical Staff of a hospital. Letters of reprimand or warning, requirements of proctoring or consultations, investigative suspensions not in excess of 14 days, requirements of further continuing medical education or training, and imposition of terms or probation which do not prevent a practitioner from exercising any privileges which have been granted to them shall not constitute adverse action and shall not give rise to rights to a hearing or appeal. Further, automatic suspensions for failure to complete medical records in a timely fashion, to maintain licensure, DEA and/or CSR registration, to maintain professional liability insurance and to qualify as a health care provider under Indiana's Medical Malpractice Act, or to complete any requirements of continuing medical education or to attend Medical Staff or committee meetings shall not be deemed adverse action.
2. **ALLIED HEALTH PROFESSIONALS** means all individually licensed health care providers who may be hospital employees, or employees of physicians, or who are independent contractors and who have been granted specified clinical privileges within the Hospital. All AHP must have a supervising physician who is a member of the Medical Staff in good standing. Allied Health Professionals are governed by these Bylaws but are not members of

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the Medical Staff. Allied Health Professionals shall not have the right to admit patients to the hospital.

3. BOARD OF TRUSTEES or BOARD means the Hospital's Board of Trustees
4. CHIEF OF STAFF means the chief officer to the Medical Staff elected by members of the Medical Staff.
5. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a practitioner to render specific patient services.
6. DAYS as used in the Bylaws with respect to time allowed for delivery or receipt of Notice shall mean calendar days (i.e. including Saturdays, Sundays and holidays). If the due date for Notice falls on a weekend or holiday, the due date shall be extended to the next working day thereafter. The time limits set forth herein shall be goals subject to good faith attempts at compliance, and failure to achieve those goals shall not give rise to rights of action.
7. DIRECT ECONOMIC COMPETITION shall pertain to any medical practice of an individual who would with reasonable probability have a financial benefit from the outcome of any professional review action taken against a practitioner.
8. EMERGENCY PHYSICIANS shall consist of practitioners whose duties shall be limited to the treatment of patients in the emergency department and shall not have admitting privileges.
9. EXECUTIVE DIRECTOR means the person appointed by the Board of Trustees to serve as the Hospital's Chief Executive Officer.
10. HOSPITAL means Dearborn County Hospital.
11. LOCUM TENENS are practitioners serving for a current member of the Medical Staff and may only attend patients of the member(s) for whom they are providing coverage, for a period not to exceed 90 days, unless the Medical Executive Committee recommends a longer period for good cause.
12. MEDICAL EXECUTIVE COMMITTEE means the Executive Committee of the Medical Staff, which shall constitute the Board of Trustees of the Medical Staff as described in these Bylaws.
13. MEDICAL STAFF or STAFF means those physicians, dentists, or podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.
14. MEDICAL STAFF YEAR means the period from January 1st through December 31st.
15. MEMBER means, unless otherwise expressly limited, any physician, dentist, or podiatrist holding a current license to practice within the scope of their license that is a member of the Medical Staff.
16. MEMBERSHIP ONLY Medical Staff members who have not utilized hospital privileges for two or more years but desire to maintain membership of the medical staff can request Membership Only status. No privileges are granted. Only practitioners who are currently members in good

standing can request such membership. New applicants are not permitted to request Membership Only status.

17. PEER REVIEW COMMITTEE shall mean the Board of Trustees, Medical Executive Committee or any committee of the Medical Staff so designated, including a committee of the whole Medical Staff, or their designated agents having the responsibility for evaluation, recommendation or making a determination concerning qualifications of a practitioner or patient care rendered by a practitioner, or the merits of a complaint against a practitioner. Peer Review Committee functions shall include the review of competence and professional conduct of a practitioner leading to determinations concerning the granting of privileges or Medical Staff membership, the scope and condition of such privileges or membership, and the modification of such privileges or membership. Evaluation of appropriate patient care by a peer review committee shall include the accuracy of diagnosis, propriety, appropriateness, or necessity of care, utilization of services, procedures and facilities of the hospital, and providing care in a nondisruptive nature.
18. PEER REVIEW INQUIRY shall mean a contemporaneously or subsequently prepared report of an unusual occurrence which concerns patient care and which is communicated to personnel of a peer review committee. All such reports shall be deemed the initiation of and part of a peer review investigation.
19. PEER REVIEW PERSONNEL means not only members of the committee, but also all of the committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves a peer review committee in any capacity, including any person under contract or other formal agreement.
20. PHYSICIAN means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.
21. PHYSICIAN EXTENDERS means persons who may provide specified health care within the Hospital as the employees of physicians, dentists or podiatrists and who do not qualify for independent privileges.
22. PRACTITIONER means a physician, dentist, podiatrist, or Allied Health Professional.
23. SUMMARY SUSPENSIONS are suspensions of all or any portion of a practitioner's clinical privileges for a period not to exceed fourteen (14) days during which an investigation is being conducted to see if any corrective action is necessary. Summary Suspensions may be imposed to protect either patient safety and/or the orderly operation of the Hospital in a nondisruptive manner. If a Summary Suspension is lifted or terminated within fourteen (14) days without a further recommendation for adverse action, no right to a hearing or appeal shall arise unless a Summary Suspension has been imposed on the same practitioner more than twice in any six-month period of time.

ARTICLE I

NAME OF ORGANIZATION

The name of this organization is the Medical Staff of Dearborn County Hospital.

ARTICLE II

RESPONSIBILITIES

The responsibilities of the Medical Staff of Dearborn County Hospital acting through its duly appointed and functioning-clinical services, departments, and committees and in accordance with these Bylaws are to:

- (1) Strive to achieve the goal that all patients admitted to or treated in any of the facilities, departments, or services of the hospital will receive quality healthcare services and associated services as appropriate.
- (2) Discharge those duties and responsibilities delegated to it by the Board, 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 receive quality healthcare services and associated services as appropriate.
- (3) Act as peer review committees and professional review bodies, to make recommendations to the Board concerning the appointment or reappointment of an applicant or practitioner to the Medical Staff of the hospital; to recommend to the Board the clinical privileges such applicant or practitioner will have in the hospital and to review and evaluate on an continuing basis such clinical privileges as have been given; and to recommend to the Board an appropriate action that may be necessary in connection with any practitioner, to the end that there will be an adequate level of professional performance by all practitioners authorized to practice in the hospital.
- (4) Establish procedures whereby issues concerning the hospital Medical Staff and the hospital management or Board may be discussed both within the Medical Staff and with the Board and the Management of the hospital.
- (5) Establish specific Rules and Regulations to govern actions and professional responsibilities of practitioners.
- (6) Provide an educational setting that will maintain scientific standards, lead to continuous advancement in professional knowledge and skill, and encourage and support such clinical basic research as from time to time approved by the Board of Trustees.
- (7) Cooperate with universities and other institutions, where appropriate, in undergraduate, graduate and postgraduate education.

ARTICLE III

MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

No physician, dentist or podiatrist shall admit or provide medical or health-related services to patients in the hospital unless they are a member of the Medical Staff with clinical privileges or have been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 General Qualifications

Only physicians, dentists and podiatrists who comply with this section shall be deemed to possess basic qualifications for membership in the Medical Staff, except for special categories in which case these criteria shall only apply as deemed individually applicable by the Medical Staff. Board certification will not be the sole determination of membership; however, lack of board certification can be grounds for denial of membership.

- (a) document: 1) current licensure, DEA & CSR (if required) 2) adequate experience, education, and training, 3) current professional competence, 4) good judgment and character, and 5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff and Board of Trustees that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;
- (b) are determined: 1) to adhere to the ethics of their respective professions, 2) to be able to work cooperatively with others so as not to adversely affect patient care or the orderly functioning of the hospital, and 3) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff;
- (c) Furnish a current certificate of professional liability insurance with coverage in the State of Indiana with the minimum limit of liability if qualified under the Indiana Malpractice Act and by paying the surcharge. If not so qualified, the minimum limit shall be \$1,000,000/\$3,000,000. Practitioners' insurance company must be admitted or authorized to conduct business in the State of Indiana.

3.2-2 Particular Qualifications

- (a) Physicians, An applicant for physician membership in the Medical Staff, except for the honorary staff, must hold a M.D. or D.O. degree issued by a medical or osteopathic school and must hold a valid unlimited license to practice medicine issued by the Medical Licensing Board of Indiana and who has successfully completed at least one year of post doctoral training in an accredited program.
- (b) Dentists, An applicant for dental membership in the Medical Staff, except for the honorary staff, must hold a D.D.S. or equivalent degree issued by a dental school and

must hold a valid unlimited license to practice dentistry issued by the Dental Licensing Board of Indiana.

Privileges granted to dentists shall be based on their training, experience and demonstrated competence and judgment. 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 privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the initial history and physical examination of each patient 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. No dentist shall be permitted to admit a patient to the hospital without the concurrence and sponsoring of the patient by a physician member of the Medical Staff (sponsoring: H&P of a patient; care of any medical condition that arises whether or not it is related to the current admission). The dentist shall be responsible for recording on the patient's chart an admitting dental history and physical examination with a detailed description of the examination and preoperative diagnosis, a complete operative report describing the procedure, reason, and results of specific actions, progress notes, and a discharge summary statement. Oral surgeons permitted by their licensure and training may apply for privileges to perform histories and physical examinations for admission of their patients.

- (c) Podiatrists. An applicant for podiatric membership in the Medical Staff, except for the honorary staff, must hold a D.P.M. degree issued by a school of Podiatric Medicine and must hold a valid unlimited license to practice podiatry issued by Podiatric Medicine Board of Indiana.

Privileges granted to podiatrists shall be based upon their training, experience, and demonstrated competence and judgment. 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 Chief of Surgery. All podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the initial history and physical examination of each patient and shall be responsible for the care of any medical problem that may be present at that time of admission or that may arise during hospitalization. No podiatrist shall be permitted to admit a patient to the hospital without the concurrence and sponsoring of the patient by a physician member of the Medical Staff (sponsoring: H&P of a patient; care of any medical condition that arises whether or not it is related to the current admission). The podiatrist shall be responsible for recording on the patient's chart an admitting podiatric history and physical examination with a detailed description of the examination and preoperative diagnosis, a complete operative report describing the procedure, reason, and results of specific actions, progress notes, and a discharge summary statement.

3.3 UNIFORM APPLICATION FOR MEMBERSHIP

There are no "waivers" to the criteria for membership. This also applies to Allied Health Professionals. No practitioner shall be entitled to membership in the Medical Staff merely

because they hold a certain degree, are licensed to practice in this or any other state, are a member of any professional organization, are certified by any clinical board, or because such person had, or presently has, staff membership or privileges at this or another health care facility, or is an employee of the hospital.

3.4 NONDISCRIMINATION

No aspect of Medical Staff membership shall be denied on the basis of sex, sexual preference, citizenship, religion, age, race, color, national origin or a disability not affecting the ability to deliver health care services with or without reasonable accommodation.

3.5 RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the Honorary Staff, the ongoing responsibilities of each member of the Medical Staff include:

- (a) Providing their patients with provision of continuous care/supervision and the quality of care meeting the professional standards of the Medical Staff of this hospital;
- (b) Abiding by the Medical Staff Bylaws, Medical Staff Rules and Regulations Manual, Medical Staff Organizational Manual and the Bylaws of the Board of Trustees, and all medical staff policies and procedures in force and as amended during the time the practitioner is appointed to the Medical Staff of the hospital.
- (c) Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments and proctoring.
- (d) Preparing and completing in timely fashion medical records for all the patients to whom the practitioner provides care in the hospital.
- (e) Abiding by the lawful and ethical principles of the professional association of the profession in which the practitioner is licensed.
- (f) Aiding in any Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel.
- (g) Working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care or the orderly functioning of the hospital.
- (h) Making appropriate arrangements for coverage for their patients as determined by the Medical Staff Rules and Regulations.
- (i) Refusing to engage in improper inducements for patient referral.
- (j) Participating in continuing education programs as determined by the Medical Staff.
- (k) Participating in such Emergency Call Schedule or consultation panels as may be determined by the Medical Staff.

- (l) Discharging such other staff obligations as may be lawfully established from time to time by the Board of Trustees, the Medical Staff or Medical Executive Committee.
- (m) Timely payment of Medical Staff dues and assessments.
- (n) Attendance at General Medical Staff and Service Meetings as established by the Medical Staff.
- (o) Shall immediately advise the appropriate Chief of Service of any significant health status changes that may affect their ability to practice medicine.

ARTICLE IV

MEMBERSHIP CATEGORIES

4.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Courtesy, Provisional, Honorary, and Emeritus. A member shall meet all applicable requirements in Article III in addition to the following qualifications and prerogatives. At each time of reappointment, the practitioner's staff category shall be determined.

4.2 PROVISIONAL STAFF

4.2-1 Qualifications

The Provisional Staff shall consist of practitioners who:

- (a) Meet the general membership qualifications set forth in Sections 3.2.
- (b) New applicants immediately prior to their application and appointment were not practitioners or were no longer practitioners in good standing of this Medical Staff.

4.2-2 Rights

The Provisional Staff practitioners shall be entitled to:

- (a) Exercise such clinical privileges as are granted pursuant to Article VII.
- (b) Attend meetings of the Medical Staff, including open committee meetings and education programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
- (c) May serve upon committees, but shall not be eligible to hold office in the Medical Executive Committee.

4.2-3 Term of Provisional Staff Status

A practitioner shall remain in the Provisional Staff for a period of one year, unless that status is extended by the Medical Executive Committee and approved by the Board for an additional period of up to one (1) year upon a determination of good cause, which determination shall not be subject to review pursuant to Articles VIII or IX.

4.3 ACTIVE STAFF

4.3-1 Qualifications

The Active Staff shall consist of members who:

- (a) Meet the general membership qualifications set forth in Sections 3.2.
- (b) Regularly care for patients in this hospital or are regularly involved in Medical Staff functions, as determined by the Medical Staff and approved by the Board of Trustees.
- (c) Except for good cause shown as determined by the Medical Staff, have satisfactorily completed appointment in the provisional staff.

4.3-2 Rights

Except as otherwise provided, the Active Staff practitioner shall be entitled to:

- (a) Admit patients and/or exercise such clinical privileges as are granted pursuant to Article VII.
- (b) Members may vote on matters presented at general and special meetings of the Medical Staff and of the committees of which they are a member.
- (c) M.D. and D.O. members may be Officers and serve as voting members of committees to which they are duly appointed or elected by the Medical Staff or duly-appointed representative thereof.

4.4 COURTESY STAFF

4.4-1 Limitation

Limited to a combination of twenty-five (25) patient procedures, admissions, or observations per calendar year. Consultants are not included.

4.4-2 Qualifications

The Courtesy Staff shall consist of members who:

- (a) Meet the general membership qualifications set forth in Section 3.2.
- (b) Do not regularly care for or are not regularly involved in the Medical Staff functions as determined by the Medical Staff.

- (c) Have satisfactorily completed appointment in the provisional staff.

4.4-3 Rights

Except as otherwise provided, the Courtesy Staff member shall be entitled to:

- (a) Admit patients to the hospital within the limitations of Section 4.4-1 and exercise such clinical privileges as are granted pursuant to Article VII.
- (b) Attend in a nonvoting capacity meetings of the Medical Staff, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
- (c) May serve upon committees, but shall not be eligible to hold office in the Medical Staff organization.

4.5 HONORARY STAFF

4.5-1 Qualifications

The Honorary Staff shall consist of practitioners who no longer hold clinical privileges but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous, long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

4.5-2 Rights

Honorary members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital, or to vote or hold office in this Medical Staff organization, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend Medical Staff meetings, including open committee meetings and educational programs.

4.6 EMERITUS STAFF

4.6-1 Qualifications

The Emeritus Staff shall consist of practitioners who have reached the age of sixty-five (65) and meet the general medical staff qualifications set forth in Section 3.2.

4.6-2 Rights

Emeritus Staff shall have the same rights and responsibilities associated with their previous membership category to included attendance at Service Meetings and General Medical Staff meetings, but shall not be required to serve on committees or participate on Emergency Department Call Schedule.

4.7 MEMBERSHIP RIGHT EXCEPTIONS

Regardless of the category of membership in the Medical Staff, unless otherwise required by law, limited license members shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, those issues shall be determined by the chairman of the meeting, subject to final decision by the Medical Executive Committee.

4.8 STAFF CATEGORY MODIFICATION

- 4.8-1 Members: May request a change in membership category. Examples: Active to Emeritus or Active to Courtesy (if within the limitations for Courtesy). Requests for modifications shall be reviewed by the appropriate committees.
- 4.8-2 Medical Executive Committee: On its own or upon recommendation of the Credentials Committee, the Medical Executive Committee may recommend a change in the Medical Staff category of a member.

ARTICLE V ALLIED HEALTH PROFESSIONALS

At the discretion of the Board of Trustees, in consultation with the Medical Staff, Allied Health Professionals who are licensed to provide care to patients may be appointed as Allied Health Professionals with appropriate privileges to provide care to patients at the Hospital or to order outpatient diagnostic work if appropriate. Such Allied Health Professionals shall be governed by the Bylaws and Rules and Regulations of the Medical Staff but shall not be members of the Medical Staff and shall not have the right to vote or to admit patients to the Hospital. Allied Health Professionals must have a supervising physician who is a member of the medical staff in good standing.

An Allied Health Professional will not be denied appointment as an Allied Health Professional provider with appropriate privileges because of possible financial competition with fully privileged members of the Medical Staff.

5.1 QUALIFICATIONS

- (a) document 1) current licensure, DEA & CSR (if required) 2) adequate experience, education, and training, 3) current professional competence, 4) good judgment and character, and 5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff and Board of Trustees that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;
- (b) are determined 1) to adhere to the ethics of their respective professions, 2) to be able to work cooperatively with others so as not to adversely affect patient care or the orderly functioning of the hospital, and 3) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff;

- (c) Furnish a current certificate of professional liability insurance with coverage in the State of Indiana with the minimum limit of liability if qualified under the Indiana Malpractice Act and by paying the surcharge. If not so qualified, the minimum limit shall be \$1,000,000/\$3,000,000. Practitioners' insurance company must be admitted or authorized to conduct business in the State of Indiana.

5.2 SUPERVISING PHYSICIAN'S OBLIGATIONS

- (a) Approve the AHP's Delineation of Privileges indicating that they will at all times undertake the supervision of the AHP in the Hospital and will be responsible for the acts or omissions of the AHP within the Hospital;
- (b) The supervising physician shall be responsible for the care of the patient and provide direction for procedures performed by the AHP.
- (c) Must authorize all procedures performed and assumes responsibility for the validity of the observations and for the proper performance of the procedures.

ARTICLE VI

APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL

By applying to the Medical Staff or Allied Health Professional Staff for appointment or reappointment (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws and agrees that throughout any period of membership they will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules and Regulations of the Medical Staff and Board of Trustees as they exist and as they may be modified. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

6.2 CRITERIA FOR APPOINTMENT

6.2-1 Initial Application

Medical Executive Committee shall make recommendations on all initial applications for membership which are based upon an assessment of the applicants:

- (a) education
- (b) licensure
- (c) training
- (d) clinical competence
- (e) affiliations
- (f) professional character
- (g) ability to work with others in a cooperative manner in the provision of health care
- (h) physical and mental health, which shall mean the ability to perform the essential functions of the privileges applied for, with or without reasonable accommodations

- (i) professional liability coverage
- (j) query of the National Practitioner Data Bank and AMA (where applicable), the Office of Inspector General and a criminal background check
- (k) timely and accurate completion of medical records

6.2-2 Reappointment

Reappointment to the Medical Staff shall be based upon an assessment of the reapplicants:

- (a) current clinical competence
- (b) licensure
- (c) professional character
- (d) ability to work with others in a cooperative manner in the provision of health care
- (e) physical and mental health, which shall mean the ability to perform the essential functions of the privileges applied for, with or without reasonable accommodations
- (f) professional liability coverage
- (g) query of the National Practitioner Data Bank and the Office of Inspector General
- (h) attendance at medical staff and committee meetings
- (i) timely and accurate completion of medical records
- (j) utilization of facilities
- (k) quality assessment
- (l) any incident reports involving the practitioner

6.3 PROVISIONAL APPOINTMENT AND REAPPOINTMENT DURATION

Provisional appointment shall be for a period of one (1) year. Reappointment shall be for a period of up to two (2) years.

6.4 ACTION ON APPLICATIONS

6.4-1 Credentials Committee

The Credentials Committee shall review the application, evaluate and verify the supporting documentation, recommendations and other relevant information in accordance with the Credentialing Manual. The Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the Medical Executive Committee a written report with its recommendations as to appointment and, if appointment is recommended, as to membership category, service affiliation, clinical privileges to be granted and any special conditions to be attached to the privileges. The committee may also recommend that the Medical Executive Committee defer action on the application.

6.4-2 Medical Executive Committee

At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the recommendations and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation and/or elect to interview the applicant. The Medical Executive Committee shall forward to the Board of Trustees a written report with its recommendation as to appointment and, if appointment is recommended, as to

membership category, service affiliation, clinical privileges to be granted and any special conditions to be attached to the privileges. The committee may also defer action on the application.

6.4-3 Board of Trustees

The Board of Trustees as the final authority shall act on the application based upon the recommendations of the Medical Executive Committee in accordance with the Medical Staff Bylaws and the Board of Trustees Bylaws.

Pursuant to Article IV, if the recommendation is unfavorable and the applicant has not previously been afforded the right to an evidentiary hearing, they shall have such an opportunity before a hearing committee appointed by the Board and may thereafter have the right to an appeal before the Board as provided in these Bylaws or in the Bylaws of the Board.

ARTICLE VII

CLINICAL PRIVILEGES FOR MEDICAL STAFF & ALLIED HEALTH PROFESSIONALS

7.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws for emergency privileges, a practitioner providing clinical services at this Hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the Medical Staff Rules and Regulations, Board of Trustees' Bylaws, and the authority of the appropriate committee and the Medical Staff.

7.2 TEMPORARY CLINICAL PRIVILEGES

Temporary privileges may be granted after review of the applicant's credentials file by the Department Director (if applicable) and appropriate Chief of Service(s). Upon their approval the Chief of Staff or in the Chief of Staff's absence the Vice Chief of Staff, and Executive Director, acting as the authorized agents of the Board of Trustees may grant temporary privileges.

7.2-1 General Conditions

- (a) If granted temporary privileges, the practitioner shall act under the supervision of the Chief of Service(s) to which the practitioner has been assigned and shall be bound by the Bylaws and Rules & Regulations.
- (b) A practitioner shall not be entitled to the procedural rights afforded by Article IX because a request for temporary privileges is refused or because all or any portion of temporary privileges are terminated or suspended. Temporary privileges are a matter of grace and do not confer any form of membership on the Medical Staff or any right to a hearing or appeal for any refusal or termination of such temporary privileges.

7.2-2 Circumstances/Procedures

- (a) New Applicants – Upon the request of an applicant, temporary clinical privileges may be granted after review by the Chief of Service prior to Credentials Committee action on initial application.
- (b) Case of Emergency - Any practitioner, to the degree permitted by their license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. Such practitioner shall make every reasonable effort to communicate promptly with the appropriate committee chairman concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, any such emergency privileges shall automatically terminate and the practitioner shall defer to the Chief of Service with respect to further care of the patient at the hospital.
- (c) Care of Specific Patient – May be granted where good cause exists to care for a specific patient.
- (d) Locum Tenens - May be granted to a practitioner serving as a locum tenens for a current member of the Medical Staff. Such person may attend only patients of the member(s) for whom they are providing coverage.

7.2-3 Duration

Temporary Privileges may be granted for a period not to exceed 90 days, unless the Medical Executive Committee recommends for good cause a longer duration.

7.2-4 Termination

- (a) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the Medical Executive Committee or Executive Director upon recommendation of the appropriate committee or unless affirmatively renewed.
- (b) Temporary privileges may be terminated by the Chief of Service(s), Chief of Staff, Vice Chief of Staff, or Executive Director acting as a peer review committee. In such cases, the appropriate Chief of Service or in their absence, the Chief of Staff shall assign a member of the Medical Staff to assume responsibility for the care of such practitioner's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member.

7.3 NONDISCRIMINATION

No aspect of Clinical Privileges shall be denied on the basis of sex, sexual preference, citizenship, religion, age, race, color, national origin or a disability not affecting the ability to deliver health care services with or without reasonable accommodation.

7.4 DELINEATION OF PRIVILEGES

7.4-1 Delineations of Privileges Form

Each department of the Medical Staff shall be required to draft a delineation of privileges available to practitioners in that department with guidelines as to the level of training and expertise required for the granting of any such privileges.

7.4-2 Requests

Each application for appointment and reappointment to the Medical Staff or AHP must contain a request for the specific clinical privileges desired by the practitioner, except for members requesting membership only reappointment.

7.5 LIMITATION OF PRIVILEGES

Privileges set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular privilege by the Medical Executive Committee and Board of Trustees Bylaws.

7.6 CO-ADMITTING

A requirement for “co-admission” means the practitioner has no clinical privileges. Another physician must admit the patient and provide for management of the patient’s care, including all orders, progress notes, and discharge instructions. A practitioner with no clinical privileges may not write in the chart, give orders, or bill for hospital visits of patients, although the practitioner may visit the patient at the hospital and provide informal input to the admitting physician.

Imposition of co-admission as part of a corrective action or an investigation is an adverse action.

7.7 MEMBERSHIP ONLY

Medical Staff members who have not utilized hospital privileges for two or more years but desire to maintain membership of the medical staff can request Membership Only status. No privileges are granted. Only practitioners who are currently members in good standing can request such status.

7.8 EMERGENCY PRIVILEGES FOR NON-MEMBERSHIP

In the event of an emergency and/or disaster, any non-member of the Medical Staff, to the degree permitted by their license shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. Such practitioner shall promptly yield such care to qualified members of the Medical Staff when they become reasonably available. If possible prior to treating patients or as soon as possible thereafter, the Medical Staff office will identify the non-member as a licensed physician through primary source verification from the hospital where the medical volunteer has privileges –

verbal verification is acceptable. Volunteers shall complete an Emergency/Disaster Information Release Authorization.

Assignments during an emergency and/or disaster are outlined in Plan Blue Mass Casualty of the DCH Emergency Preparedness/Disaster Plans.

Disaster Plan Blue, Level I, is the operational response when the Emergency Department needs to expand its facilities and/or staff because of unusually circumstances, such as several patients arriving at one time.

Disaster Plan Blue, Level II, is the operational response when a large number of victims are being brought to the Emergency Department in a short period of time whose treatment requires the hospital's resources to be mobilized rapidly and brought to bear in a concentrated effort.

7.9 MODIFICATION OF CLINICAL PRIVILEGES

7.9-1. Practitioners' Request for a modification of clinical privileges may be requested after their provisional review, but such requests must be supported by documentation of training and clinical competence.

7.9-2 Medical Executive Committee's Recommendation – On its own, upon recommendation of the Credentials Committee, or pursuant to a request under Section 6.3 of the Credentialing Manual, the Medical Executive Committee may recommend a change in the clinical privileges of a practitioner. Such a recommendation shall then be forwarded to the Board of Trustees for final action.

ARTICLE VIII

CORRECTIVE ACTION

8.1 CORRECTIVE ACTION

8.1-1 Criteria for Initiation

Any person may provide information to the Medical Staff about the conduct, performance, or competence of a practitioner. When reliable information indicates a practitioner may have exhibited acts, demeanor, or conduct, reasonably likely to be (1) detrimental to patient safety or to the orderly delivery of quality patient care within the hospital; (2) unethical; (3) contrary to the Medical Staff Bylaws and Rules and Regulations; or (4) below applicable professional standards, request for an investigation or action against such practitioner may be initiated by any officer of the Medical Staff, by the Chief of Service, by the chairman of any standing committee of the Medical Staff, by the Executive Director, or by the Board of Trustees.

8.1-2 Initiation

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. The Medical

Executive Committee shall be responsible for evaluating all requests for corrective action and shall either conduct an investigation of any such request if it deems the matter to be of significance, or shall oversee the investigation by a body or person whom it shall assign this function. The investigating body or person shall then report to the Medical Executive Committee.

8.1-3 Investigation

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate standing or ad hoc committee of the Medical Staff. If the investigation is delegated to a committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action.

The practitioner is not notified that an investigation is being conducted. If necessary the practitioner shall be given an opportunity to provide information in a manner and upon such terms as the investigation body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a 'hearing' as that term is used in Article IX, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee, with immediate notification to the Executive Director, shall retain authority and discretion to take any Summary Suspension as may be warranted by the circumstances.

8.1-4 Medical Executive Committee Action

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action which may include, without limitation:

- (a) Determining no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, including its findings of lack of credible evidence with any adverse information in the practitioner's quality file.
- (b) Deferring action for a reasonable time where circumstances warrant.
- (c) Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude committee chairmen from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected practitioner may make a written response which shall be placed in the practitioner's quality file.
- (d) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.
- (e) Recommending reduction, modification, suspension or revocation of clinical privileges.

- (f) Recommending reduction of membership status or limitation of any privileges directly related to the practitioner's delivery of patient care.
- (g) Recommending suspension, revocation or termination of Medical Staff or Allied Health Professional membership.
- (h) Taking other actions deemed appropriate under the circumstances.

8.1-5 Subsequent Action

If adverse action as set forth in Section 9.2 is recommended by the Medical Executive Committee, the practitioner shall receive notice of the proposed adverse action and shall be afforded their right to a hearing and appeal as specified in Article IX.

8.2 SUMMARY SUSPENSION

8.2-1 Criteria for Initiation

Any two of the following individuals, acting as a peer review committee and professional review body, or any one of the committees listed below shall have the authority to summarily suspend the clinical privileges of any practitioner in the hospital:

- (1) Chief of Staff,
- (2) Vice Chief of Staff – Secretary/Treasurer,
- (3) Executive Director of the hospital or in his or her absence, his or her designee,
- (4) Medical Executive Committee, or
- (5) Chairman of the Board of Trustees

8.2-2 Authority

The above have the authority to summarily suspend all or any portion of the clinical privileges of a practitioner whenever failure to take such action may result in real potential danger to patients or to conduct an orderly investigation of the matter. Such suspension will not imply any final finding of responsibility for the situation that caused the suspension. The committee of two or more individuals above or the committee, which exercised its authority under these Bylaws to summarily suspend the privileges of a practitioner, will immediately report the action to the Medical Executive Committee. At that point, the Medical Executive Committee may refer the matter to the committee for further investigation pursuant to the provisions for requests for corrective action or may take such further action itself as is required in the manner specified under these Bylaws.

Summary suspension can also be invoked due a practitioner's behavior or physical or mental health.

8.2-3 Notification to Practitioner

Such summary suspension will become effective immediately upon oral notice to the practitioner to be confirmed promptly by certified mail, return receipt requested, or by personal delivery; will immediately be reported in writing to the Executive Director, or, in his or her absence, his or her designee, and will remain in effect unless or until modified by review within fourteen (14) days by the Medical Executive Committee or by the Executive Director or the Board of Trustees. The practitioner will thereafter be entitled to the procedural rights contained in these Bylaws.

8.2-4 Duration of Action

The summary suspension will remain in force after the Medical Executive Committee takes responsibility for a period not to exceed fourteen (14) days of investigation or for an indefinite period if the Medical Executive Committee determines that failure to take such action may result in real potential danger to patients. All suspensions will be deemed to be investigative in nature during the first fourteen (14) days in which they are in effect.

8.2-5 Care of Suspended Practitioner's Patients

Immediately upon the imposition of a summary suspension, the appropriate Chief of Service or, in their absence, the Chief of Staff will assign to one or more Medical Staff member(s) responsibility for care of the suspended practitioner's patients still in the hospital at the time of such suspension until such time as they are discharged or choose another physician with privileges to take care of them. It will be the duty of the Chief of Staff and the Chief of Service to cooperate with the Executive Director in enforcing all suspensions.

8.2-6 Medical Executive Committee Action

As soon as practicable and not more than fourteen (14) days after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be conveyed to review and consider the action. Upon request, the practitioner may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the practitioner, constitute a "hearing" within the meaning of Article IX, nor shall any procedural rules apply. The practitioner's failure without good cause to attend any Medical Executive Committee meeting upon request shall constitute a waiver of his or her rights under Article IX. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the practitioner with written notice of its decision. The suspension may not be continued beyond fourteen (14) days unless the committee makes the finding specified in Section 8.2-4.

8.2-7 Procedural Rights

Unless the Medical Executive Committee promptly terminates the summary suspension, the practitioner shall be entitled to the procedural rights afforded by Article IX.

8.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the practitioner's privileges or membership may be suspended or limited as described. Such action shall be final without a right to hearing or further review except

- (a) Procedure Rights - Automatic revocations or suspensions do not give rise to a hearing or appeal, and are imposed by notice to the affected practitioner by the Medical Executive Committee or Executive Director and are automatically terminated by the practitioner's compliance with the involved requirement.
- (b) Practitioner Dispute – If a bona fide dispute exists as to whether the circumstances occurred, the practitioner may ask for an informal meeting with the Medical Executive Committee to state any grounds to dispute the facts giving rise to any automatic suspension.

8.3-1 Licensure

- (a) Revocation, expiration or suspension: Whenever a practitioner's license or other legal credential authorizing practice in this State is revoked, expired, or suspended, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.
- (b) Restriction: Whenever a practitioner's license or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the practitioner has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- (c) Probation: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, their membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
- (d) Revocation or Suspension of Licensure: However if the reason for the summary suspension was because of a revocation or suspension of licensure by the Medical Licensing Board of Indiana, an appropriate review of the facts and circumstances surrounding same will be conducted prior to reinstatement.

8.3-2 Controlled Substance Registrations

- (a) Revocation, limitation, expiration or suspension Whenever a practitioner's DEA or CSR certificate is revoked, limited, or suspended, the practitioner shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
- (b) Probation: Whenever a practitioner's DEA certificate is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to

the same terms of the probation, as of the date such action becomes effective and throughout its term.

8.3-3 Professional Liability Insurance

Failure to maintain professional liability insurance shall be grounds for automatic suspension of a practitioner's clinical privileges, and if within 90 days after written warnings of the delinquency the practitioner does not provide evidence of required professional liability insurance, the practitioner's membership shall be automatically terminated.

Any notification of cancellation or failure to renew professional liability insurance or failure to pay the surcharges to qualify under the Indiana Medical Malpractice Act, shall automatically suspend any practitioner's privileges in the hospital until such coverage is reestablished.

8.3-4 Failure to Satisfy Special Appearance Requirement

A practitioner who fails without good cause to appear and satisfy the requirements of the Organization Manual Section 3.6.3 shall automatically be suspended from exercising all or such portion of clinical privileges as may be specified in accordance with the provisions of that section.

8.3-5 Medical Records

Practitioners are required to complete medical records within such reasonable time as prescribed by the Medical Staff in its Rules and Regulations. Failure to do so will subject the practitioner to a temporary suspension of privileges as determined by the Medical Staff in its Rules and Regulations. Bona fide illness may constitute an excuse, subject to approval by the Medical Executive Committee. Scheduled vacations or other absences may excuse a practitioner if a variance is requested and approved in advance.

8.4 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Section 8.3.4 the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth under requests for corrective action and/or summary suspensions.

Automatic suspensions for any reason other than completion of medical records, renewal of licensure, or reinstatement of professional liability insurance shall not be lifted until reviewed by the Medical Executive Committee within fourteen days of imposition by action of the Medical Staff or within fourteen days of release of any action by any agency outside the hospital. Automatic suspension for licensure or controlled substance matters will be reviewed by the Medical Executive Committee for any basis for corrective action by the Medical Staff itself before any automatic suspension is lifted.

ARTICLE IX

HEARINGS AND APPELLATE REVIEWS

9.1 GENERAL PROVISIONS

9.1-1 Exhaustion of Remedies

If adverse action described in Section 8.2 is taken or recommended, the applicant or practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

9.1-2 Application of Article

- (a) For purposes of this Article, the term "practitioner" includes applicant, medical staff members and allied health professional as it may be applicable under the circumstances.
- (b) Under Section 1.9.3 of the Credentialing Manual, circumstances may arise in which the Board of Trustees provides an initial hearing. In such cases, the procedures set forth herein for hearings before the judicial review committee shall generally apply to hearings before the Board, except as reasonably modified by the Board.

9.2 GROUNDS FOR HEARING

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

- (a) Denial of Medical Staff membership;
- (b) Denial of requested advancement in staff membership status, or category;
- (c) Denial of Medical Staff appointment;
- (d) Demotion of lower staff category or membership status
- (e) Suspension of staff membership for longer than 30 days;
- (f) Revocation of Medical Staff membership;
- (g) Denial of requested clinical privileges (excluding temporary privileges);
- (h) Involuntary reduction of current clinical privileges (excluding temporary privileges);
- (i) Suspension of clinical privileges (excluding temporary privileges and privileges suspended in accordance with 8.3-4) for longer than 30 days;
- (j) Termination of all clinical privileges (excluding temporary privileges);

- (k) Involuntary imposition of consultation or monitoring requirements which prevent a practitioner from exercising their privileges without obtaining the permission or agreement of the proctor or consultant.

9.3 REQUESTS FOR HEARING

9.3-1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Section 9.2, the Executive Director shall give the practitioner prompt written notice of the following: the proposed recommendation or action; reasons for the proposed recommendation or action; that the practitioner has the right to request a hearing on the proposed recommendation or action; that the practitioner shall have 30 days following receipt of notice of such recommendation or action to request a hearing; and a summary of the following hearing rights: the required hearing, if not forfeited by the practitioner if they fail without good cause to appear shall be held before a panel of individuals who are appointed by the Executive Director after consultation with the Medical Executive Committee and who are not in direct economic competition with the practitioner involved. In the hearing the practitioner has the right:

(1) to representation by an attorney or other person of the practitioner's choice, (2) to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof, (3) to call, examine, and cross-examine witness, (4) to present relevant evidence regardless of its admissibility in a court of law, (5) to submit a written statement at the close of the hearing, (6) to receive the written recommendation of the panel, including a statement of the basis for the recommendations, and (7) to receive a written decision of the panel, including a statement of the basis for the decision.

9.3-2 Request for Hearing

The practitioner shall have thirty (30) days following receipt of written notice of such action to request a hearing. The request shall be in writing addressed to the Executive Director with copies to the Board of Trustees and Medical Executive Committee. In the event the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

9.3-3 Time and Place for Hearing

Upon receipt of a written request for hearing, the Executive Director after consultation with the Medical Executive Committee shall schedule a hearing and, within fifteen (15) days (but in no event less than fifteen (15) days prior to the hearing) give the following written notice to the practitioner: the time, place and date of the hearing; and a list of the witnesses, if any, expected to testify at the hearing on behalf of the Medical Executive Committee. Unless extended by the judicial review committee, the date of the commencement of the hearing shall not be less than thirty (30) days from the date of receipt of the request by the Executive Director for a hearing; provided, however, that when the request is received from a practitioner who is under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made.

9.3-4 Reason for Adverse Action

Together with the notice of hearing, the Executive Director after consultation with the Medical Executive Committee shall state clearly and concisely in writing the reasons for the adverse action taken or recommended, including the acts of omissions with which the practitioner is charged and a list of representative charts in question or incident reports or audits, where applicable.

9.3-5 Judicial Review Committee

When a hearing is requested, the Executive Director, after consultation with the Medical Executive Committee shall appoint a judicial review committee which shall be composed of not less than (3) individuals who are not: in direct economic competition, blood relatives, employee/employer relationship or other potential conflicts with the practitioner involved. Participation in the consideration of the matter leading up to the recommendation or action or knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the judicial review committee. In the event that it is not feasible to appoint a judicial review committee from the Active Medical Staff, the Executive Director may appoint members from other staff categories or practitioners or other qualified individuals who are not members of the Medical Staff and who are not in direct economic competition with the practitioner involved. Such appointment shall include designation of the chairman.

9.3-6 Failure to Appear or Proceed

Failure without good cause of the practitioner to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved. Determination of good cause will be made by the judicial review committee and shall not be subject to appeal other than to the Board of Trustees.

9.3-7 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the judicial review committee, or its chairman acting upon its behalf, within the discretion of the committee or its chairman on a showing of good cause.

9.4 HEARING PROCEDURE

9.4-1 Pre-Hearing Procedure

- (a) If either side to the hearing requests in writing a list of witnesses, within 15 days of such request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. While neither side in a hearing shall have any right to discovery of documents or other evidence in advance of the hearing, the hearing officer must confer with both sides to encourage an advance

mutual exchange of documents which are relevant to the issues to be presented at the hearing.

- (b) It shall be the duty of the practitioner and the Executive Director or Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chairman of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing. The judicial review committee with the advice of the hearing officer shall be empowered to rule on any objections to procedure or evidence and/or any challenges to the members sitting on the committee.

9.4-2 Representation

The hearings provided for in these Bylaws are for the purpose of inter-professional resolution of matters bearing on professional conduct, professional competency, or character. The practitioner and the Medical Executive Committee may be represented in any phase of the hearing by legal counsel. In the absence of legal counsel, the practitioner shall be entitled to be accompanied by and represented at the hearing by any other person. The Medical Executive Committee may appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and responses to appropriate questions. The Medical Staff representative may be represented by legal counsel in performing these tasks.

9.4-3 The Hearing Officer

The Executive Director after consultation with the Medical Executive Committee shall appoint a hearing officer, who is not a member of the judicial review committee, to preside at the hearing and give legal advice to the members of the judicial review committee. The hearing officer shall not be in direct economic competition with the practitioner. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the hospital for legal advice regarding its affairs and activities shall not be eligible to serve as hearing officer. The hearing officer must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

9.4-4 Record of Hearing

A court reporter shall be present to make a record of the hearing proceedings, and the proceedings may be recorded electronically, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the recorder shall be borne by

the hospital, but the cost of the transcript, if any, shall be borne by the part requesting it. The judicial review committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

9.4-5 Rights of the Parties

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the Medical Executive Committee and examined as if under cross-examination.

9.4-6 Miscellaneous Rules

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The judicial review committee may interrogate the witness or call additional witnesses if it deems such action appropriate. The judicial review committee shall permit both sides to file written arguments.

9.4-7 Burdens of Presenting Evidence and Proof

At the hearing, unless otherwise determined for good cause, the Medical Executive Committee shall have the initial duty to present evidence of each case or issues in support of its action or recommendation. The practitioner shall be obligated to present evidence in response. Throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

9.4-8 Adjournments and Conclusion

After consultation with the chairman of the judicial review committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if requested, the hearing shall be closed.

9.4-9 Basis for Decision

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the judicial review committee shall be final, subject to the provisions of Section 9.5 hereof.

9.4-10 Decision of the Judicial Review Committee

Within fifteen (15) days after final adjournment of the hearing, the judicial review committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee.

If the practitioner is currently under suspension, however, the time for the decision and report shall be as quickly as possible, but no later than fifteen (15) days. A copy of said decision shall also be forwarded to the Executive Director, the Board of Trustees and to the practitioner. The report shall contain a concise statement of the reasons in support of the decision. The decision of the judicial review committee shall be forwarded to the Board of Trustees for final action, subject only to such rights of appeal or review as described in these Bylaws as are exercised or deemed to be waived.

9.5 APPEAL

9.5-1 Time for Appeal

Within ten (10) days after receipt of the decision of the judicial review committee, either the practitioner or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Executive Director, and the other side in the hearing. If a request for appellate review is not requested within such period, the right to the appeal shall be deemed to have been waived, and the matter will be forwarded to the Board of Trustees for their action.

9.5-2 Grounds for Appeal

A written request for an appeal shall include an identification of the grounds for appeal, and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial noncompliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 9.5-5.

9.5-3 Time, Place, and Notice

If an appellate review is to be conducted, the appeal board shall, within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of such notice; provided, however, that when a request for appellate review concerns a practitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made. The time for appellate review may be extended by the appeal board for good cause.

9.5-4 Appeal Board

The Board of Trustees may sit as the appeal board, or it may appoint an appeal board which shall be composed of not less than three (3) members of the Board of Trustees. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal

board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

9.5-5 Appeal Procedure

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the judicial review committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the judicial review committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel in connection with the appeal, to present a written statement in support of their, or its position on appeal and, in its sole discretion, the appeal board may allow each party or representative or counsel therefore to appear personally and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Board of Trustees its written recommendations as to whether the Board of Trustees should affirm, modify, or reverse the judicial review committee decision, or remand the matter to the judicial review committee for further review and decision.

9.5-6 Decision

- (a) Except as otherwise provided herein, within 30 days after the conclusion of the appellate review proceeding, the Board of Trustees shall render a decision in writing and shall forward copies thereof to each side involved in the hearing.
- (b) The Board of Trustees may affirm, modify, or reverse the decision of the judicial review committee or remand the matter to the judicial review committee for reconsideration. If the matter is remanded to the judicial review committee for further review and recommendation, said committee shall promptly conduct its review and make its recommendations to the Board of Trustees. This further review and the time required to report back shall not exceed 30 days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chairman of the Board of Trustees and the judicial review committee.
- (c) In the event the decision of the Board of Trustees is unfavorable to the applicant, that action shall become final and shall not be subject to any further hearing, appeal, or other review. The Board's decision at that point shall be final and shall not be subject to any further hearing, appeal or other review.

9.5-7 Right to One Hearing

No practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter, which shall have been the subject of adverse action or recommendation.

9.5-8 Exhaustion of Administrative Remedies

As a condition of applying for or accepting privileges as a member of the Medical Staff, Allied Health Professional, or for any other privileges which may be requested, the applicant binds himself or herself to exhaust all administrative remedies contained in these Bylaws before seeking any kind of judicial review in any state or federal court or other tribunal.

9.6 EXCEPTIONS TO HEARING RIGHTS

9.6-1 Automatic Suspension or Limitation of Practice Privileges

No hearing is required when a practitioners license or legal credentials to practice has been revoked or suspended as set forth in Section 8.3-1. In other cases described in Section 8.3, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing board, credentialing authority or the DEA was unwarranted, but only whether the practitioner may continue practice in the hospital with those limitations imposed.

9.6-2 Reporting Adverse Action

When final action is taken by the Board of Trustees which constitutes an adverse action as defined in the Bylaws, the Executive Director or his/her designee shall report such adverse action to the Medical Licensing Board for referral to the National Practitioner Data Bank within fifteen (15) days of the adverse action. The Executive Director shall also be responsible for reporting any suspensions, or other adverse actions which are not based upon final action of the Board of Trustees when such suspension or restriction last more than thirty (30) days.

The Executive Director is responsible for filing any corrections or modification of notices of adverse actions.

**ARTICLE X
OFFICERS**

Officers of the Medical Staff shall be the Chief of Staff and the Vice Chief of Staff – Secretary/Treasurer, all of whom must be and must remain members of the Active Staff. The manner of election and removal of officers, the duties of officers, the functions, order of business, and agendas of the departments and of all committees shall be specified in the Medical Staff Organizational Manual.

**ARTICLE IX
MEDICAL EXECUTIVE COMMITTEE**

11.1 COMPOSITION

The Medical Executive Committee shall consist of the following Active Medical Staff Members and hospital personnel:

11.1-1 Officers

Chief of Staff and Vice Chief of Staff – Secretary/Treasurer.

11.1-2 Chiefs of Service

The Chiefs-of-Services of Medicine, Surgery, Obstetrics, and Pediatrics who must be an M.D. or D.O.

11.1-3 Member at Large

One At-Large member of the Active medical staff.

11.1-4 Hospital Based

One Hospital Based physician elected to represent the following specialty areas: Anesthesia, Emergency Medicine, Pathology, or Radiology.

11.1-5 Hospital Personnel

The Executive Director as a non-voting, ex-officio member, Director of Patient Care Services, Director of Health Information Management, Physician Quality Advisor and the Medical Staff Coordinator. Also a Board of Trustee member shall attend the meetings.

11.2 DUTIES

The duties of the Medical Executive Committee shall include, but not be limited to:

- (a) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff.
- (b) Receiving and acting upon reports and recommendations from Medical Staff committees, and assigned activity groups.
- (c) Recommending action to the Medical Staff.
- (d) Participating in the development of all Medical Staff and hospital policy, practice, and planning.
- (e) Reviewing the qualifications, credentials, performance and professional competence and character of applicants and practitioners and making recommendations to the Board of Trustees regarding staff appointments and reappointments, clinical privileges, and peer review action.
- (f) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all practitioners including the initiation of and participation in Medical Staff corrective review measures when warranted.

(g) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff.

(h) Reporting to the Medical Staff at each regular staff meeting.

(i) Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff.

11.3 MEETINGS

The Medical Executive Committee shall meet as often as necessary, but at least once a month and shall maintain a record of its proceedings and actions.

11.4 NOMINATIONS

Nominations shall be completely voluntary. If there are not two members who meet the criteria; the nominating committee shall select two suitable nominees.

11.5 RUN OFF ELECTION

If there are more than two candidates for a position on the Medical Executive Committee, a runoff election shall be initiated. Eligible voting members will be instructed to vote for only one candidate on the run-off ballot. The top two candidates receiving the most votes will be placed on the slate.

11.6 TERM OF OFFICE

Terms shall begin on January 1 and end on December 31.

11.6-1 Officers & Chiefs of Service

Shall serve a term of two years upon election. There shall be no automatic succession of Officers. A practitioner could succeed himself or herself in the position of Chief of Staff, Vice Chief – Secretary/Treasurer, or Chief of Service.

11.6-2 Member at Large and Hospital Based Members

Shall serve a one-year term upon election.

ARTICLE XII

SERVICE MEETINGS

The business of the Medical Staff shall be carried out on a regular basis at the Service meetings. If any service has fewer than three members or if all of its members are partners or shareholders in a

single partnership or professional corporation, the Medical Executive Committee shall review the methods for conducting peer review within that service to seek effective performance of this duty.

ARTICLE XIII

CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS

By applying for membership or exercising clinical privileges within this hospital, a practitioner:

- (a) Authorizes representatives of the hospital, personnel of peer review committees, and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the practitioner's clinical competence and qualifications.
- (b) Signs an Authorization to Release information permitting persons and organizations to provide information concerning such practitioner to the Medical Staff.
- (c) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital or personnel of peer review committees who act in accordance with the provisions of this Article.
- (d) Acknowledges that the provisions of this Article are expressed conditions required for Medical Staff or Allied Health Professional membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

13.2 CONFIDENTIALITY OF INFORMATION

Members of the Medical Staff who are involved in the evaluation and improvement of the quality of patient care rendered (i.e. Medical Staff Officers, Department Medical Director, Service Chiefs, Committee Chair or members, or an individual physician working under the auspices of a peer review committee) recognize that they will be provided with and have access to very sensitive and confidential information regarding practitioner credentialing, performance improvement and peer review activities and results of criminal background checks.

13.2-1 General

All such information, discussions, and deliberations shall be in strict confidence, to the fullest extent permitted by law and privileged.

Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee. Unauthorized dissemination of peer review material shall constitute grounds for corrective action.

13.2-2 Breach of Confidentiality

- (a) Inasmuch as effective peer review and consideration of the qualifications of practitioners and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action, as it deems appropriate. It is further understood that such breach may result in the loss of available legal protection.
- (b) All persons involved in the credentialing process must be aware of the fact that unauthorized release of information obtained from National Practitioners Data Bank is a violation of the law which may subject the person to a civil money penalty of up to \$11,000 per occurrence.

13.3 IMMUNITY FROM LIABILITY

13.3-1 Action Taken

All personnel of peer review committees of the Medical Staff and Hospital shall be exempt, and have absolute immunity to the fullest extent permitted by law, from liability to an applicant or practitioner for damages or other relief for any action taken or statements or recommendations made within the scope of their duties as personnel of a peer review committee of the Medical Staff or Hospital.

13.3-2 Providing Information

Personnel of peer review committees of the Medical Staff and Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or practitioner for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an applicant or practitioner of the Medical and Allied Health Professional staffs or who did, or does exercise clinical privileges at this hospital.

13.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning, but not limited to:

- (a) Applications for appointment, reappointment, or clinical privileges;
- (b) Corrective action;
- (c) Hearings and appellate reviews;
- (d) Utilization reviews;

- (e) Other committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

13.5 RELEASES

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

ARTICLE XIV

GENERAL PROVISIONS

14.1 AUTHORITY TO ACT

Any practitioner who acts in the name of this Medical Staff without proper authority shall be subject to such corrective action, as the Medical Executive Committee may deem appropriate.

14.2 CREDENTIALS FILES

The credentials file on each individual practitioner in the Hospital shall be kept in a secure manner. Access to the file shall be confined to officers of the Medical Staff and administration. The practitioner has the right to access all information in their file at anytime.

14.2-1 Confidentiality

The following applies to records of the Medical Staff and its committees responsible for the evaluation and improvement of patient care:

- (a) The records of the Medical Staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the Hospital shall be maintained as confidential peer review records.
- (b) Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.
- (c) Information, which is disclosed to the Board of Trustees of the hospital or its appointed representatives in order that the Board of Trustees may discharge its lawful obligations and responsibilities, shall be maintained by that body as confidential.
- (d) Information contained in the credentials file of any practitioner may be disclosed with the practitioner's consent to any Medical Staff, hospital, professional licensing board, or peer review committee.

- (e) Request for transfer of information between health care facilities, which demonstrate a legal right to information concerning practitioner, shall be made in writing, and such information shall be privileged in accordance with Indiana peer review immunity statute.

14.3 DIVISION OF FEES

Any illegal division of fees as defined as illegal by Indiana statute or regulation by practitioner is forbidden, and any such division of fees shall be cause for corrective action by the Medical Staff.

14.4 DUES OR ASSESSMENTS

Subject to the approval of the Medical Staff, the Medical Executive Committee shall have the power to recommend the amount of dues or assessments, if any, and to determine the manner of expenditure of such funds received. Dues are to be paid at the time of initial application and reappointment.

New applicants will be billed for the costs associated with conducting a criminal background check.

14.5 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as Medical Staff representatives to local, state, and national hospital Medical Staff sections (HMSS) should be filled by such selection process as the Medical Staff may determine.

14.6 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, or requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service, first class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Mailed notices to a practitioner, applicant or other party shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the hospital.

14.7 QUALITY ASSURANCE FILES

A quality assurance file shall be established on all practitioners. These files will be separate from credentials files and will contain only information relative to quality assurance matters. These files will be used primarily at reappointment time. The practitioner has the right to access all information in their file at anytime that they are under investigation. Whenever any information is inserted in the practitioner's quality assurance file, the practitioner has the right to be notified that potentially adverse information is being inserted in their file, has the right to review that information before it is inserted, and has the right to submit a written response to the incident report or committee report. The practitioner's written response will be maintained in the quality assurance file in the same manner as adverse information report. Included in these files will be: requested IOP reviews, physician profiles, liability insurance claims including reports from the NPDB, committee/staff meeting

attendance records, suspensions due to delinquent medical records; and copies of letters written to the practitioner from the Medical Executive Committee. These files will be kept in the Administration office. Administration will have access to the files. As appropriate, the Department Chairman, Chief of Service(s), Credentials Committee, and the Chief of Staff may access the file.

14.8 RULES AND REGULATIONS

The Medical Executive Committee shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall review every two years and revise, if necessary, Rules and Regulations to comply with current Medical Staff practice. Applicants and practitioners shall be governed by such Rules and Regulations as are properly initiated and adopted. If there is a conflict between the Bylaws and Rules and Regulations, the Bylaws shall prevail.

14.9 TERMS AND HEADINGS

The terms and headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both sexes wherever either term is used.

14.10 VOTING ELIGIBILITY

14.10-1 Active and Emeritus Active Staffs who are in good standing are eligible to vote on proposed Bylaws changes, election of Medical Executive Committee members, and at committees they have been appointed to or elected to serve on.

14.10-2 Courtesy, Membership Only, Honorary Emeritus Courtesy, and Provisional Staffs are not eligible to vote on proposed Bylaws changes or election of Medical Executive Committee members, nor at committees, unless specified at the time of appointment.

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ARTICLE XV

REVIEW, AMENDMENTS, APPEALS, AND ADOPTION CREDENTIALING, ORGANIZATIONAL, AND RULES & REGULATIONS MANUALS

15.1 REVIEW

The Medical Executive Committee shall review the Credentialing, Organizational, and Rules and Regulations manuals every two years. The Credentials Committee shall review the Credentialing Manual every two years.

15.2 AMENDMENT PROCEDURE

One month prior to the submission of proposed Amendment(s) to the Credentialing Manual, Organizational Manual, or Rules and Regulations Manual, eligible voting members of the Medical Staff shall be notified of the proposed recommended Amendment(s) that will be presented to the Medical Executive Committee.

A vote from the Medical Staff is not required for these Amendments, members will be instructed to contact the Chief of Staff or their respective Chief of Service or Department Chairman with concerns or comments on the proposed Amendment(s).

The Credentialing Manual, Organizational Manual, and Rules and Regulations Manual may be amended or repealed, in whole or in part, at a duly called, regular meeting of the Medical Executive Committee with a majority vote provided a quorum exists.

15.3 APPEALS

Any member or members of the Medical Staff may appeal adopted Amendments to the Credentialing Manual, Organizational Manual, or Rules and Regulations Manual. A written petition signed by at least 10% of eligible voting members of the Medical Staff must be received within three (3) months following the adoption of the Amendment(s). The petition shall be addressed to the Chief of Staff and will be discussed at the next regular meeting of the Medical Executive Committee and put to a vote of the eligible Medical Staff members.

15.4 ADOPTION

Upon adoption by the Medical Executive Committee, the amendments shall become effective after approval of the Board of Trustees.

ARTICLE XVI REVIEW, AMENDMENT AND ADOPTION OF BYLAWS

16.1 REVIEW

These Bylaws shall be reviewed every two years by the Bylaws Committee and a report given to the Medical Executive Committee and the Board of Trustees.

16.2 AMENDMENT PROCEDURE

These Medical Staff Bylaws may be amended or repealed, in whole or in part, upon the request of the Bylaws Committee, Chief of Staff, the Medical Executive Committee, or upon timely written petition signed by at least 10% of the Medical Staff entitled to vote.

The Bylaws Committee and the Medical Executive Committee must approve any proposed amendments or repeals. Upon their approval, a written ballot will be sent to all Medical Staff members eligible to vote. The ballot shall include the exact current language of existing Bylaws section, if any, and the proposed change(s). Ballots shall have the printed name and signature of the voting member.

16.2-1 Changes required by Law

Changes to the Bylaws required to comply with Federal and State Laws shall be brought to the attention of the Bylaws and Medical Executive Committees and will be automatically changed in the Medical Staff Bylaws. The medical staff cannot vote on such required changes mandated by law.

16.3 OFFICIAL ELECTION AND MAJORITY RULE

51% of the ballots must be returned for an official election. Of that 51% returned, a 2/3rds majority must be received for the recommended amendment to be adopted.

Example:

85 Ballots sent out, 43 must be returned for an official election. 28 of 43 ballots returned must be in favor of the recommended Amendment for adoption.

16.4 ADOPTION

Following adoption by the Bylaws Committee, Medical Executive Committee, and a favorable vote by the Medical Staff members eligible to vote, the Amendments shall become effective after approval by the Board of Trustees.

16.5 EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

ARTICLE XVII

ADOPTION

17.1 MEDICAL EXECUTIVE COMMITTEE

These Medical Staff Bylaws were adopted and recommended to the Board of Trustees by the Medical Executive Committee in accordance with and subject to the Medical Staff Bylaws.

Jim Cole, M.D. Chief of Staff

July 8, 2008
Date

17.2 BOARD OF TRUSTEES

These Medical Staff Bylaws were approved and adopted by resolution of the Board of Trustees after considering the Medical Executive Committee's recommendations and in accordance with the Board of Trustees' Bylaws.

Ronald Denney, Chairman
Board of Trustees

July 23, 2008
Date

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