MEDICAL STAFF BYLAWS

OF

DEACONESS HOSPITAL, INC.

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BYLAWS OF THE MEDICAL STAFF

OF DEACONESS HOSPITAL

PREAMBLE

WHEREAS, Deaconess Hospital, Inc. ("Deaconess Hospital") is a nonprofit corporation organized under the laws of the State of Indiana and owns or has significant ownership interests in four other hospitals--Deaconess Women's Hospital, Deaconess Cross Pointe Center, Deaconess Gateway Hospital, and Deaconess Heart Hospital;

WHEREAS, among the purposes of Deaconess Hospital are maintaining comparably high medical staff professional standards among all five Hospitals ("the Hospitals") and avoiding duplication of effort in credentialing medical staff applicants and reapplicants and in reviewing requests for corrective action; and

WHEREAS, it is recognized that the medical staff is delegated the initial responsibility for the quality of medical care in the Hospitals and must accept and discharge this responsibility as the agent of the Hospital governing boards in its review of medical care and subject to the ultimate authority of the governing boards, and that the cooperative efforts of the medical staff, the Chief Executive Officers ("CEOs") of the Hospitals and governing boards are necessary to fulfill the Hospitals' obligation to their patients; and

WHEREAS, the governing boards of the Hospitals, the medical staff, 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 as defined in the Health Care Quality Improvement Act of 1986 and as peer review committees as defined by the Indiana Peer Review Act, IC 34-6-2-99, and claim all of the privileges and immunities of those acts.

THEREFORE, the physicians, dentists and allied health care providers practicing in the five Hospitals hereby organize one unified medical staff among the five hospitals and a unified appointment, reappointment and peer review process in conformity with these Bylaws.

DEFINITIONS

1. The term "advanced practice nurse" shall mean certified nurse-midwives, nurse practitioners and clinical nurse specialists as defined by Indiana Code §25-23-1-1 and 848 IAC art. 4.

2. The term "adversely affecting or adverse action" shall mean any action based on professional review activity reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges of a practitioner or membership on the medical staff. Letters of reprimand or warning, requirements of proctoring or consultations, investigative suspensions not in excess of fourteen (14) days, requirements of further continuing medical education or training, and imposition of terms of probation which do not prevent a practitioner from exercising any privileges which have been granted to him or her shall not constitute adverse action and shall not give rise to rights to a hearing or

appeal. Punitive suspensions not exceeding thirty (30) days in length are not adverse actions, do not give rise to the right to a hearing or appeal, and are not reportable to the National Practitioner Data Bank or Medical Licensing Board. Further, automatic suspensions for failure to complete medical records in a timely fashion, to comply with the electronic clinical information system training and use provisions, to maintain licensure or DEA registration, to maintain professional liability insurance and to qualify as a health care provider under the Patients Compensation Act, to complete any requirements of continuing medical education, or to fail to pay annual dues shall not be deemed "adverse action."

3. The term "allied health care provider" means all individual health care providers other than doctors of medicine or osteopathy and dentists who may qualify to exercise specified clinical privileges at the Hospitals. Allied health care providers are governed by these Bylaws but are not members of the medical staff.

4. The term "board certification" means a medical specialty certification board recognized by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists and Boards of Certification.

5. The term "Chief Executive Officer" ("CEO") means the individual appointed by the governing board of each Hospital to act in its behalf in the overall management of the Hospital.

6. The term "Chief Medical Officer ("CMO") shall mean the Vice President and Chief Medical Officer of Deaconess Hospital.

7. The term "clinical privileges" shall mean privileges, membership on the medical staff, and other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care at the Hospitals. "Clinical privileges" does not include assignment to categories, departments, or committees, or participation in medical staff functions by allied health care providers.

8. The term "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.

9. The term "direct economic competition" shall mean 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.

10. The term "governing boards" of the Hospitals means, respectively, the Board of Directors of Deaconess Hospital, Inc., for Deaconess Hospital, Deaconess Gateway Hospital, Deaconess Heart Hospital and Deaconess Cross Pointe Center and the Board of Managers for Deaconess Women's Hospital of Southern Indiana, LLC.

11. The term "Hospitals" means Deaconess Hospital, Inc., Deaconess Women's Hospital, Deaconess Cross Pointe Center, Deaconess Gateway Hospital and Deaconess Heart Hospital.

12. The term "incident/occurrence report" shall mean a contemporaneously or subsequently prepared report of an incident or occurrence which concerns patient care and which is communicated to personnel of a peer review committee. All such reports shall be deemed to be the initiation of and part of a peer review investigation.

13. The term "investigative 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. Investigative suspensions are instituted in the same manner and are reviewable in the same manner as a summary suspension. Investigative suspensions may be imposed to protect either patient safety and/or the orderly operation of any Hospital in a non-disruptive manner. If an investigational suspension is lifted or terminated in fourteen (14) days or less without a further recommendation for adverse action, no right to a hearing or appeal shall arise unless an investigative suspension has been imposed on the same practitioner more than twice in any six-month period of time.

14. The term "licensed independent practitioner" means any individual permitted by law and by the Hospitals to provide care, treatment, and services without direction or supervision. "Licensed independent practitioners" are not a separate or additional category of individuals permitted to provide care to patients within the Hospitals. An individual applying for privileges as a licensed independent practitioner must qualify for privileges as a physician, dentist or allied health provider. Credentialing, monitoring of practice, and review of the quality of care for licensed independent practitioners shall be performed as provided for physicians, dentists or allied health providers.

15. The term "maintain a practice within the service area of the Hospitals" shall mean that a physician must be available to visit each of his or her patients daily and must respond to patients needing attention at the Hospitals within a medically reasonable period of time, twenty-four hours a day, seven days per week. A physician may meet this obligation personally or by coverage by another physician who has privileges in the same area of medical practice.

16. The term "MEC" means the Medical Staff Executive Council.

17. The terms "medical/dental staff " or "staff" mean all doctors of medicine or osteopathy and dentists who through formal appointment as staff members are thereby privileged to attend patients at the Hospitals.

18. The term "peer review committee" shall mean the governing board of each Hospital and any committee of the medical staff or governing boards or their designated agents which evaluates, recommends, or takes actions based on the competence or professional conduct of an individual practitioner or Hospital employee and which affects or may affect the clinical privileges or membership on the medical staff of any practitioner, the scope or

conditions of such privileges or membership, or any changes or modifications in such privileges or membership. The function of a peer review committee shall include evaluation of qualifications of professional health care providers which includes the performance of patient care and related duties in a manner that is not disruptive to the delivery of quality medical care in the Hospital setting and evaluation of patient care which includes the accuracy of diagnosis, propriety, appropriateness or necessity of care rendered by a professional health care provider, and the reasonableness of the utilization of services, procedures and facilities in the treatment of individual patients.

19. The term "personnel of peer review committee" 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. The term "practitioner" means an appropriately licensed medical and osteopathic physician, dentist or allied health care provider.

21. The term "professional review action" means an action or recommendation of a peer review committee which is taken or made in the conduct of professional review activity or peer review.

22. The term "professional review activity or peer review activity" includes all of the functions of a peer review committee as defined, including a formal decision of such a committee not to take an action or make a recommendation.

ARTICLE I - NAME

The name of this organizational unit of Deaconess Hospital shall be the unified Medical Staff of Deaconess Hospital, Inc.

ARTICLE II - PURPOSES

The purposes for which this medical staff is organized shall be:

A.. To promote appropriate standards of medical practice in the Hospitals;

B. To conduct peer review activity as the agent of the Hospital governing boards;

C. To serve in an advisory capacity on Hospital projects and activities in cooperation with the governing boards and the CEOs of the Hospitals;

D. To conduct regular meetings, in accordance with the requirements of nationally recognized agencies, and such special meetings as may be required, for the following purposes:

(1) To review and analyze the clinical practice of the Hospitals and report on matters of scientific interest;

(2) To consider the affairs of the Hospitals bearing upon their effectiveness in serving the medical needs of the community;

E. To provide continuing educational programs for all members of the staff.

F. To make recommendations to the governing boards regarding questions relating to the membership and privileges of the medical staff members.

ARTICLE III - UNIFIED MEDICAL STAFF

In June 2007, the medical staff members of Deaconess Hospital and Deaconess Women's Hospital (separately certified hospitals) approved the establishment of a unified Deaconess Hospital Medical Staff by a two-thirds affirmative vote in accordance with Article XIX on adoption of amendments to the bylaws. As now required by the Medicare Hospital Conditions of Participation, effective July 11, 2014 (42 CFR § 482.22(b)(4)), the medical staff members of both Deaconess Hospital and Deaconess Women's Hospital holding privileges to practice on-site at their respective hospitals retain the right to request a vote on whether that hospital's medical staff should opt out of the unified medical staff structure by following the procedures set forth below:

1. A petition requesting a vote to opt out of the unified medical staff must be signed by not less than twenty-five percent (25%) of the eligible voting members of the separately certified hospital's medical staff in order to hold a vote. Eligible voting members are members classified under Article XI as Active Staff (non-provisional) or Senior Staff. The petition must be submitted to the President of the unified Medical Staff for a vote in accordance with one of the voting processes described in Article XIX. The MEC shall select the method to be used for voting. As required by Article XIX, the affirmative vote of two-thirds (2/3) of the voting membership present or who return ballots during the time period specified by the MEC shall be required for approval, subject to the subsequent approval of that Hospital's governing board.

2. A vote to opt out of a unified medical staff may not be held more frequently than once every two years.

3. All members of the unified medical staff are advised in writing at the time of initial appointment and at reappointment of their right to initiate a vote to opt out of the unified medical staff as described above. A copy of the notice is placed in their credentials file.

4. The unified Deaconess Hospital Medical Staff was established in a manner that took into account the unique circumstances of each of the two separately certified hospitals and the differences in patient populations and services offered in each hospital, which can have implications for medical staff functions and other responsibilities of the medical staff under federal and state regulatory requirements and accreditation standards.

5. The unified Deaconess Hospital Medical Staff has established and implemented policies and procedures to ensure that the needs and concerns expressed by members of the Medical Staff at Deaconess Hospital and Deaconess Women's Hospital (the two separately certified hospitals), regardless of practice or location, are given due consideration, and there are mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed.

ARTICLE IV - PERSONS GOVERNED BY BYLAWS

A. Persons Governed. These Bylaws shall govern applicants for and members of the medical staff and allied health care providers.

B. Residents. Residents are practitioners who are currently enrolled in a graduate medical education program and who, as part of their educational program, provide health care services at the Hospitals under the supervision and direction of members of the medical staff. Residents are not considered members of the medical staff and are not entitled to rights and privileges under the Medical Staff Bylaws, including the right to a hearing and appellate review of adverse actions under Article VIII and the Fair Hearing Plan. Residents must hold or secure, and maintain, either a permanent or temporary license to practice medicine from the Indiana Medical Licensing Board. Residents may write all types of diagnostic and treatment orders for patients without being required to obtain a countersignature from a supervising physician except as may be otherwise specified in the medical staff or departmental rules and regulations.

C. Not A Contract. These Bylaws are not a contract of any kind between the Hospital governing boards, the medical staff and the allied health care providers. The continuance of a practitioner's privileges at the Hospitals is based solely upon his or her continuing ability to justify the exercise of such privileges, and the privileges do not obligate a practitioner to practice at the Hospitals. The governing boards and medical staff are obligated by law to use fairness in dealing with persons governed by these Bylaws but do not bind themselves to the particular means of doing so set forth in these Bylaws.

ARTICLE V - STAFF MEMBERSHIP

A. Qualifications.

(1) A physician or dentist may qualify for membership on the medical staff and for privileges if he or she provides adequate documentation of:

a. licensure in Indiana as a physician or dentist;

b. training, experience and demonstrated competence;

c. ability to maintain his or her practice within the service area of the Hospitals;

d. adherence to the code of ethics of the American Medical Association, American College of Surgeons, the American Dental Association or the

American Osteopathic Association, whichever is applicable, and a good reputation;

e. ability to work with others in a cooperative, professional manner in the provision of patient care and in the orderly functioning of the Hospitals;

f. ability to make efficient use of Hospital facilities so as not to jeopardize the financial stability of the Hospitals;

g. good physical, mental and emotional health; and

h. qualification as a health care provider under the Indiana Medical Malpractice Act, IC 34-18-3, which includes filing proof of financial responsibility and paying the surcharge to the Commissioner of Insurance.

(2) The documentation provided by the physician or dentist must be sufficient to assure the medical staff and Hospital governing boards that any patient treated by the physician or dentist in the Hospitals will be given an appropriate level of medical care.

(3) No physician or dentist shall be entitled to membership on the staff or to the exercise of particular clinical privileges in the Hospitals merely by virtue of the fact that he or she is duly licensed to practice medicine or dentistry in this or in any other state, or that he or she is a member of any professional organization, or that he or she had in the past or presently has any such privileges at these or other hospitals, or that he or she is employed by the Hospitals.

(4) No decisions on staff membership or privileges will be influenced by an applicant's race, religion, sex, sexual orientation, age, national origin, or citizenship or on the basis of any handicap which does not affect a practitioner's ability to provide care to patients with or without reasonable accommodations.

(5) Certification by the Education Commission for Foreign Medical Graduates is required for graduates outside of the United States and Canada.

B. Obligations.

(1) Application for and/or acceptance of membership on the medical staff shall constitute the agreement of the applicant or staff member to:

a. Abide by the Principles of Medical Ethics of the American Medical Association, American Osteopathic Association, American College of Surgeons or the American Dental Association, whichever is applicable, as well as the Deaconess Health System Code of Conduct when practicing in the Hospitals. These professional ethical codes are made a part of these Bylaws (see Appendix "B");

b. Abide by all of the terms and provisions of these Bylaws as they now exist and as they shall be amended; by all of the rules and regulations of the medical staff as may now exist and as they shall be amended; by all of the policies and procedures of the Hospitals and Deaconess Health System as they now exist and as they shall be amended.

c. Authorize the members of the medical staff as agents of the Hospital governing boards to investigate and to gather any relevant information which would otherwise be confidential or privileged concerning the applicant or staff member with regard to his or her qualifications to exercise privileges in the Hospitals;

d. Authorize all persons and organizations to release such information to the Hospital governing boards, their agents and/or employees;

e. Release and hold harmless all persons, organizations (including the Hospitals), the governing boards of the Hospitals, personnel of peer review committees, their agents, employees and all others who participate in good faith in providing, receiving, evaluating, or taking any action on such information regarding the applicant or staff member;

f. Certify compliance with all state and federal statutes and regulations and hospital policies governing referrals, billing for services rendered to patients at the Hospitals, and conflicts of interest and obligation to document compliance on request; and

g. Conduct himself or herself at all times at the Hospitals without discrimination or harassment on the basis of race, color, religion, national origin, disability which with or without reasonable accommodation does not prevent the performance of the essential functions of a job or access to medical care, age, sex, sexual orientation, or any other unlawful or impermissible criterion.

h. Notify promptly the Hospitals in writing if the applicant or staff member has been excluded from participation in the Medicare and Medicaid program, convicted of a felony, or has had his or her professional license, CSR or DEA certificates or clinical privileges at any facility terminated, reduced, restricted, suspended or modified.

(2) It is the duty of the medical staff as the agent of the Hospital governing boards to examine the credentials of all persons requesting privileges as members of the medical staff or as allied health care providers and to recommend to the governing boards specific delineation of privileges.

(3) It is the duty of each member of the medical staff to maintain and demonstrate continuously the appropriate level of competence and professional conduct which would justify the continuance of staff membership and specific privileges granted. The failure of any medical staff member to demonstrate the requisite level of

competence and professional conduct in providing patient care will necessitate corrective action and may result in the termination of medical staff membership and any Hospital privileges which the staff member had been granted.

(4) All medical staff members will refrain from delegating the responsibility for diagnosis and/or care of hospitalized patients to a medical or dental practitioner who is not qualified to undertake that responsibility or to other paramedical personnel who are not adequately supervised.

(5) All medical staff members will seek consultation, when appropriate, and particularly in cases where the diagnosis is obscure, the best therapeutic measures are in doubt, or problems arise that are beyond their expertise.

(6) All active, senior and courtesy staff members and all other independent contractor practitioners are responsible for their own acts and omissions, and will carry in full force and effect, at their expense, continuous professional liability (malpractice) insurance with limits at least equal to the minimum limits provided for in the Indiana Medical Malpractice Act, I.C. §34-18-4-1, will provide proof of such and pay the surcharge to the Commissioner of Insurance, and will promptly notify the Hospitals in writing of any change in or termination of such insurance coverage while a member of the medical staff.

(7) Each admitting staff member is responsible for providing continuous care and supervision of his or her patients, including adequate and appropriate coverage for patients when he or she is not available.

(8) All medical staff members will accept committee assignments, consultation and proctoring assignments, and participate in the educational programs of the staff and Hospitals at which they have privileges.

(9) All medical staff members will acknowledge the provisions of Section 413 of the Health Care Quality Improvement Act of 1986 which permits the recovery of reasonable attorney's fees and costs in the defense of any suit brought by a practitioner concerning clinical privileges when the defendants have acted in compliance with the standards set forth in the Act.

(10) All medical staff members agree to submit, on request, to an appropriate examination or testing of his or her physical, mental and emotional health.

ARTICLE VI - ALLIED HEALTH CARE PROVIDERS

A. Allied Health Care Providers in General.

(1) Qualifications

a. The Credentials Committee has the responsibility for developing the categories of allied health providers eligible to apply for specified clinical privileges, based on patient care and administrative needs, and the

qualifications for each category, subject to the approval of the governing boards. In general, allied health care providers may qualify for specified clinical privileges if they provide adequate documentation of:

(1) Qualification as a "health care provider" under Indiana Code §§34-18-2-14 and 34-18-3;

(2) Indiana licensure in their profession, where applicable;

(3) Education, training, experience and demonstrated competence;

(4) Adherence to the ethics of their professions, and their good reputations;

(5) Ability to work with others in a cooperative professional manner in the provision of patient care;

(6) Ability to maintain their practice within the service area of the Hospitals;

(7) Ability to make efficient use of hospital facilities so as not to jeopardize the financial stability of the Hospitals; and

(8) Good physical, mental and emotional health.

b. The documentation provided by the allied health care provider must be sufficient to assure the medical staff and governing boards that any patient treated by the allied health provider in the Hospitals will be given an appropriate level of medical care.

c. No allied health care provider shall be entitled to exercise privileges in the Hospitals merely by virtue of the fact that he or she is duly licensed to practice his or her profession in this or another state, or that he or she is a member of any professional organization, or that he or she had in the past or presently has such privileges at these or other hospitals.

d. No decisions on appointment as an allied health care provider with specific privileges will be influenced by an applicant's race, religion, sex, sexual orientation, age, national origin, or citizenship or on the basis of any handicap which does not affect a practitioner's ability to provide care to patients with or without reasonable accommodations.

(2) Obligations

a. Application for and/or acceptance of privileges as an allied health care provider shall constitute the agreement of the applicant or provider to:

(1) Abide by the code of ethics which governs his or her professional organization and the Deaconess Health System Code of Conduct;

(2) Abide by all of the terms and provisions of these Bylaws as they now exist or as they shall be amended; by all of the rules and regulations of the medical staff as may now exist and as they shall be amended; by all of the policies and procedures of the Hospitals and Deaconess Health System as they now exist and as they shall be amended;

(3) Authorize the members of the medical staff as agents of the Hospital governing boards to investigate and to gather any relevant information which would otherwise be confidential or privileged concerning the applicant or provider with regard to his or her qualifications to exercise privileges at the Hospitals;

(4) Authorize all persons and organizations to release such information to the Hospital governing boards, their agents and/or employees;

(5) Release and hold harmless all persons, organizations (including the Hospitals), the governing boards of the Hospitals, personnel of peer review committees, their agents and employees and all others who participate in good faith in providing, receiving, evaluating, or acting on such information regarding the applicant or provider;

(6) Abide by the credentialing and peer review process of the medical staff, although the providers shall not be members of the medical staff, shall not vote in medical staff elections or deliberations, and are not required to attend medical staff meetings;

(7) Certify compliance with all state and federal statutes and regulations and hospital policies governing referrals, billing for services rendered to patients at the Hospitals, and conflicts of interest and obligation to document compliance on request;

(8) Conduct themselves at all times at the Hospitals without discrimination or harassment on the basis of race, color, religion, national origin, disability which with or without reasonable accommodation does not prevent the performance of the essential functions of a job or access to medical care, age, sex, sexual orientation, or any other unlawful or impermissible criterion;

(9) Notify the Hospitals promptly in writing if the applicant or provider has been excluded from participation in the Medicare and Medicaid Program, convicted of a felony, or has had his or her professional license, CSR or DEA certificates or clinical privileges at any facility terminated, reduced, restricted, suspended or modified.

b. It is the duty of each allied health care provider to maintain and demonstrate continuously the appropriate level of competence and professional conduct which would justify the continuance of those privileges granted. The failure of any allied health care provider to demonstrate the requisite level of competence and professional conduct in providing patient care will necessitate corrective action and may result in the termination of any privileges which the allied health care providers may have been granted.

c. Each allied health care provider agrees to provide continuous care and supervision of his or her patients and to seek consultation when appropriate.

d. Each allied health care provider agrees to accept committee assignments, to accept consultation and proctoring assignments, and to participate in the educational programs of the staff and Hospitals at which he or she has privileges.

e. Each allied health care provider agrees to provide proof of continuous professional liability insurance and payment of the surcharge to qualify the practitioner as a health care provider under the Indiana Medical Malpractice Act and promptly notify the Hospitals in writing of any change in or termination of such insurance coverage while holding privileges at the Hospitals.

f. Each allied health care provider agrees to submit, on request, to an appropriate examination or testing of his or her physical, mental and emotional health.

g. Locum Tenens allied health care providers initial appointments will be for a maximum of one (1) year and will automatically terminate unless an application for continuation of such privileges is submitted by the applicant at least 120 days prior to their termination. If a timely application for continuation of such privileges is received, credentialing and privileging will be performed with respect to the application.

B. Physician Assistants.

(1) Eligibility

Physician Assistants must be registered with the Hospitals to provide specified health care at the Hospitals as (1) employee of a Hospital or (2) the employee of a physician member of the medical staff with Active, Senior or Courtesy Staff privileges or (3) an employee of a physician group who has a collaborative agreement with a physician member of the medical staff with Active, Senior or Courtesy Staff privileges. Collaborative agreements must be with MDs or DOs.

(2) Registration Process

a. Physician assistants shall apply for approval on forms provided by the CEO of the Hospital or his/her designee which shall require submission of the collaborative agreement under which the physician assistant wishes to work. The application shall also include proof of qualification under the Indiana Patient's Compensation Fund and payment of the surcharge for the Fund.

b. The Credentials Committee shall review each application and make a recommendation concerning registration to the MEC.

c. The MEC shall determine whether the physician assistant should be approved, subject to the approval of the Governing Board.

d. The MEC's recommendation may accept, modify, reject, delete or add such terms and conditions to the collaborative agreement as it may think best. The agreement of the physician assistant and the collaborating physician must be given in writing to any such terms and conditions before the matter is forwarded to the Governing Board. Such modifications may further restrict but not expand any collaborative agreement approved by the Medical Licensing Board.

e. The registration of any physician assistant terminates automatically with the termination of the collaborative agreement with his or her collaborating physician or the suspension or termination of the medical staff privileges of the collaborating physician.

(3) Obligations

a. All procedures performed by a physician assistant will be under the direction of the collaborating physician who shall be responsible for the care of the patient.

b. All procedures performed must be those authorized specifically by the collaborating physician who assumes responsibility for the validity of the observations and for the proper performance of the procedure.

c. Functions delegated to physician assistants by collaborating physicians shall be based on their training, experience, competence and judgment.

d. The scope and extent of the procedures performed by the physician assistant shall be limited to specific delegated acts, tasks or functions as they relate to the privileges of the collaborating physician.

e. Physician assistants will not write orders except at the specific direction of the collaborating physician, in which case the physician assistant will sign the order with the employer's name per his or her own name. The order must then be countersigned by the physician employer within 72 hours.

C. Advanced Practice Nurses.

(1) Eligibility

Advanced practice nurses shall include certified nurse-midwives, nurse practitioners and clinical nurse specialists as defined by Indiana Code §25-23-1-1 and 848 IAC art. 4. Advanced practice nurses practice agreements must be with MDs or DOs, or DPMs, not with DDSs Advanced practice nurses must perform their duties under practice agreements with physicians or DPMs but need not be the employees of physicians.

(2) Registration Process

a. Any advanced practice nurse who wishes to provide services at the Hospitals either as the employee of a Hospital (including Deaconess Foundation or any subsidiary of Deaconess) or as the employee of a physician member of the medical staff with Active, Senior, or Courtesy privileges or as an independent contractor who has a practice agreement with a physician who is a member of the medical staff must apply for registration on forms provided by the CEO of the Hospital or his or her designee which shall require submission of the practice agreement under which the advanced practice nurse wishes to work. If appropriate, an advanced practice nurse with authority to write prescriptions under state law may apply for privileges to perform a face-to-face evaluation of a patient who has required emergency use of behavioral restraints with reporting of the patient's condition to the treating physician or other physician within one hour of the application of the emergency restraints. The application shall also include proof of qualification under the Indiana Patients' Compensation Fund and payment of the surcharge therefor.

b. The Credentials Committee shall review each application and proposed practice agreement and make a recommendation concerning registration to the MEC.

c. The MEC shall determine whether the advanced practice nurse should be approved for registration, subject to the approval of the Hospital governing board.

d. The MEC's recommendation may accept, modify, reject, delete or add such terms and conditions to the practice agreement as it may think best. The agreement of the advanced practice nurse and the collaborating physician must be given in writing to any such terms and conditions before the matter is forwarded to the governing board. Such modifications may further restrict but not expand any practice agreement approved by the Nursing Board.

e. The registration of any advanced practice nurse terminates automatically upon the termination of the practice agreement with his or her collaborating physician or the suspension or termination of the medical staff privileges of the collaborating physician.

(3) Obligations

a. Advanced practice nurses may only provide services to patients pursuant to the practice agreements which they have with their collaborating physicians as approved by the MEC and Hospital governing board.

b. Collaborating physicians of advanced practice nurses are responsible and liable for any acts or omissions of their own in providing appropriate oversight for the advanced practice nurses.

c. Advanced practice nurses must certify compliance with all state and federal statutes and regulations and hospital policies governing referrals, billing for services rendered to patients at the Hospitals, and conflicts of interest and obligation to document compliance on request.

d. Advanced practice nurses must conduct themselves at all times at the Hospitals without discrimination or harassment on the basis of race, color, religion, national origin, disability which with or without reasonable accommodation does not prevent the performance of the essential functions of a job or access to medical care, age, sex, sexual orientation, or any other unlawful or impermissible criterion

D. Denial, Non-Renewal, Restriction, Suspension or Termination of Privileges.

a. Privileges of an allied health care provider may be non-renewed, restricted, suspended or terminated at any time by agreement of any two of the following persons: President of the Medical Staff, CMO, and CEO of the Hospital or his/her designee. If feasible, the persons or body taking the action shall consult the Department Chief and any supervising physician, as applicable, prior to taking the action.

b. Nothing in the Medical Staff Bylaws shall be interpreted to entitle an allied health care provider to the procedural rights set forth in Article VIII of the Bylaws and the Fair Hearing Plan (except to the extent that the allied health care provider has applied for or been granted privileges as an independent practitioner as covered by I.C. §§ 34-30-15-5(b) and 34-30-15-6(b)). Any allied health care provider, however, shall have the right to challenge any denial of application for appointment or registration or any action taken under the preceding section by filing a written grievance with the Credentials Committee within 15 days of such action. On receipt of such a grievance, the Credentials Committee shall conduct an investigation that shall afford the allied health care provider an opportunity for an interview concerning the grievance. Any such interview shall not constitute a hearing as that term is described in the Fair Hearing Plan, and the procedural rules applicable to such hearings shall not apply. Before the interview, the allied health care provider shall be informed of the general nature and circumstances giving rise to the action, and the allied health care provider may present information relevant thereto at the interview. A record of the interview shall be made. On the basis of the interview and all other information available to it, the Credentials Committee shall make a recommendation to the MEC. After the Credentials Committee makes a final recommendation to the MEC, the allied health care provider may then request reconsideration by the MEC of an adverse Credentials Committee recommendation. In that reconsideration, the allied health care provider may present to the MEC additional written arguments relevant to the Credentials Committee recommendation. There is no right of the allied health care provider to appear personally before the MEC. After considering the allied health care provider's additional written arguments, if any, the MEC shall make a final decision on the recommendation of the Credentials Committee (except for denials of applications which will be finally determined by the governing boards).

E. Automatic Termination.

An allied health care provider's privileges shall automatically terminate, without review, in the event:

a. The medical staff membership of a supervising or collaborating physician or dentist is suspended, terminated or relinquished (whether voluntary or involuntary);

b. Any contract between the Hospital and a supervising or collaborating physician or dentist or independent contractor employer is terminated, regardless of the reason therefor; the allied health care provider's supervising or collaborating physician or dentist no longer agrees to act as a supervisor or collaborator, for any reason, or the relationship between the allied health care provider and the supervising or collaborating

physician or dentist or independent contractor employer is otherwise terminated, regardless of the reason;

c. The allied health care provider's license or certificate to practice expires, is revoked, suspended, or otherwise restricted;

d. Either the allied health care provider or supervising or collaborating physician or dentist or independent contractor employer fails to maintain continuous professional liability insurance as required;

e. The allied health care provider is not in compliance with the electronic information system training and use provisions of the Medical Staff Rules and Regulations after a reasonable opportunity to comply.

F. Hospital Employee.

Nothing in these Bylaws shall be construed to interfere with the Hospitals' right to discipline or terminate hospital employees in accordance with hospital human resource policies.

ARTICLE VII - CLINICAL PRIVILEGES

A. Requests for Privileges.

Requests for privileges will be handled in a manner outlined by the medical staff rule and regulation entitled Credentialing Manual. In summary, except as specifically provided otherwise below, the Credentials Committee will recommend to the MEC which department or committee should be responsible for delineation of the requirements of each privilege to be granted by the medical staff. The department or committee so designated may establish minimum training and/or experience requirements that must be met by an applicant to be eligible to apply for a given privilege. Recommended requirements must be approved as amendments to the rules and regulations of the department or committee and must follow the procedures outlined in these Bylaws for amendments to the rules and regulations. The Medical Staff Office shall maintain a delineation of privileges form for each department or committee that establishes requirements for the privileges assigned to that department or committee.

B. Restriction on Privileges.

(1) The governing boards at the Hospitals will grant privileges as a member of the medical staff or as an allied health care provider only to professionally competent physicians, dentists and allied health care providers who continuously meet the qualifications, standards and requirements set forth in these Bylaws.

(2) Each practitioner practicing at the Hospitals shall be entitled to exercise only those clinical privileges specifically granted to him or her by the governing boards, except as provided in these Bylaws in the case of temporary, emergency and disaster privileges.

(3) No appointment of privileges may exceed three (3) years duration.

C. Admitting and Co-Admitting Privileges.

(1) Admitting Privileges

In order to be eligible for admitting privileges, a practitioner must:

a. hold clinical privileges at the Hospitals;

b. be licensed in a profession which is authorized to diagnose and treat conditions which regularly require inpatient hospitalization because of the severity, complexity or risk factors associated with such conditions;

c. be licensed or certified to perform a history and physical examination and to assume overall medical responsibility for a patient's care at the Hospitals;

d. be authorized by law to prescribe and approve all medications used for patient diagnosis and treatment at the Hospitals;

e. be authorized under Medicare and Medicaid to provide certification of diagnosis and of medical necessity for all inpatient services connected with a patient's care; and

f. meet other conditions as are adopted by the medical staff and approved by the Hospital governing boards.

(2) Co-Admitting Privileges

a. In order to be eligible for co-admitting privileges, a practitioner must:

(1) Hold clinical privileges at the Hospitals;

(2) Be licensed in a profession which is authorized to diagnose and treat conditions which regularly require inpatient hospitalization because of the severity, complexity or risk factors associated with such conditions; and

(3) Meet such other conditions as are adopted by the medical staff and approved by the Hospital governing boards.

b. Co-admitting privileges entitle a practitioner to admit a patient to the Hospital for treatment within such practitioner's area of licensure, subject to designating a member of the active staff with admitting privileges at the Hospitals who will be responsible for the medical care of the patient other than the specific care pertaining to the co-admitting practitioner's area of licensure.

c. A practitioner who admits a patient with a co-admitting practitioner does not accept responsibility of the care provided by the co-admitting practitioner.

D. Emergency Privileges.

(1) In the case of an emergency, any medical staff member shall be granted emergency privileges to attend such a patient until an appropriate staff member becomes available.

(2) Emergency is defined, under this section, as a situation in which the life, limb or organ of a patient is in immediate danger and in which any delay in administering treatment would increase danger.

(3) These emergency privileges shall not extend beyond the immediate need for emergency care, and shall give rise to no rights under these Bylaws.

E. Quality Measures Clinical Privileges.

In order to meet clinical quality measures established by regulatory authorities and/or payors, the Nurse Practitioner working in a quality role in the Quality Improvement Department, after an attempt to contact the attending physician and in the absence of contraindications, is authorized under a collaborative practice agreement with the Chief Medical Officer and his/her designee(s) to place orders for treatment or medication in accordance with the quality measures and document the placing of those orders through a progress note, a copy of which is sent to the attending physician.

F. Temporary Privileges.

(1) The CEO of the Hospital or his/her designee, after conference with the President of the Medical Staff or President-Elect, shall have the authority to grant temporary privileges to a physician or dentist who is not a member of the staff, or to a recognized consultant, under one of the following circumstances:

a. When a completed application is awaiting MEC and governing board approval.

b. For care of a specific patient(s)

c. For locum tenens practitioners

d. In an emergency/disaster situation

(2) *Important patient care, treatment or service need*: under this subcategory, temporary privileges may be granted after verification of licensure, DEA certificate, insurance coverage, and at least one recent reference from a previous hospital, department chief or chair familiar with the current competence of the physician.

(3) Temporary privileges are granted for a limited period of time not to exceed 120 days.

(4) Temporary privileges are extended as a matter of grace and confer upon the recipient no membership on the medical staff, no appointment as an allied health care provider, and no rights under these Bylaws.

(5) Temporary privileges may be suspended, modified or revoked at any time by the CEO of the Hospital or his/her designee or by the President of the Medical Staff without giving rise to the right to a hearing and appeal under these Bylaws.

(6) Upon suspension and/or termination of temporary clinical privileges, the President of the Medical Staff or Department Chief shall have the power to assign another medical staff member to provide alternate medical care to the patients of the suspended or terminated physician or dentist, and/or to discharge such patients from the Hospital, as appropriate.

G. Disaster Privileges.

(1) The Hospital CEOs, President of the Medical Staff or CMO and their designees are each individually authorized to grant disaster privileges to volunteer physicians, dentists and allied health care providers when the Hospital's emergency management plan has been activated and the Hospital is unable to handle immediate patient needs.

(2) In order for volunteers to be considered eligible for disaster privileges, either the CEO's office or the Medical Staff Office will obtain for each volunteer practitioner, at a minimum, a valid government – issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

a. A current picture hospital ID card that clearly identifies professional designation.

b. A current license to practice.

c. Primary source verification of the license.

d. Identification indicating that the individual is a member of a Disaster Medical Association Team (DMAT), or Medical Reserve Corps unit, Emergency System for Advance Registration of Volunteer Health Professionals or other recognized state or federal organizations or groups.

e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity).

f. Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.

(3) The medical staff oversees the professional performance of volunteer practitioners who receive disaster privileges through a combination of direct observation, mentoring, and clinical record review.

(4) Primary source verification of licensure will begin as soon as the immediate situation is under control, and will be completed within 72 hours from the time the volunteer practitioner presents to the Hospital except in extraordinary circumstances (e.g., no means of communication or a lack of resources) under which it should be completed as soon as possible.

(5) The CEO, President of the Medical Staff or CMO and their designees are not required to grant disaster privileges to any individual and are expected to make such decisions on a case-by-case basis at their discretion based on the representations of the individual as to current license/privileges and supporting documentation, to the extent available.

(6) Disaster privileges may be terminated by the CEO, President of the Medical Staff or CMO and their designees at any time. The denial or termination of disaster privileges shall not entitle a practitioner to the hearing and appellate review procedure under Appendix A, Fair Hearing Plan.

(7) Notwithstanding any existing delineation of privileges or scope of authority, during a disaster current medical staff members, Hospital employees and volunteers are authorized to take whatever steps they reasonably believe are necessary to save or preserve the life or health of patients or to protect the public health.

H. Clinical Privileges.

Each department or committee of the medical staff shall be required to draft a delineation of all possible 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. These delineations shall be adopted as rules and regulations of the medical staff after approval by the MEC and the Hospital governing boards.

I. Focused Professional Practice Evaluation.

The medical staff has defined the circumstances requiring monitoring and evaluation of a practitioner's professional performance in the peer review protocol set forth in the Medical Staff Organization Manual, the Peer Review Process policy, and in specific department peer review policies and procedures. The period of focused professional practice evaluation (FPPE) is implemented for all new privileges granted by the board, either upon initial appointment or requests for additional privileges and when issues affecting safe, high-quality patient care are identified. Such monitoring may use

prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, tracking performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of the patient. See further description of proctoring in Article IX, Chapter B.

J. Ongoing Professional Practice Evaluation.

The medical staff will also engage in ongoing professional practice evaluation ("OPPE") to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to allow practitioners to maintain existing privileges, revise existing privileges, or revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the medical staff's evaluation, measurement, and improvement of each practitioner's current clinical competency. In addition, each practitioner may be subject to focused professional practice evaluation ("FPPE") when issues affecting the provision of safe, high-quality patient care are identified during the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

K. Telemedicine.

Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. The medical staff recommends which clinical services are appropriately delivered through this medium, consistent with commonly accepted quality standards.

Physicians and dentists who are responsible for a patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the Hospitals (the site where the patient is located at the time the service is provided) through one of the following mechanisms:

a. The Hospitals may fully privilege and credential the practitioner according to the procedures set forth in Articles VII and VIII of these Bylaws and the Credentialing Manual; or

b. The practitioner may be privileged at the Hospitals using credentialing information from the distant site if the distant site is accredited by a CMS approved national accreditation body, and the practitioner holds a license issued or recognized by the Medical Licensing Board; or

c. The Hospitals may use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met through its written agreement with the distant site:

(1) The distant site is an accredited Medicare-participating hospital or telemedicine entity furnishing the contracted telemedicine services

in a manner that permits the Hospitals to comply with all applicable Medicare conditions of participation;

(2) The practitioner is privileged at the distant site for those services to be provided at the Hospitals, and the distant site provides a current list of the practitioner's privileges;

(3) The practitioner holds a license issued or recognized by the Indiana Medical Licensing Board; and

(4) The Hospitals have evidence of an internal review of the practitioner's performance of these privileges and send to the distant site such performance information for use in the periodic appraisal of the practitioner. At a minimum, this information includes all adverse events that result from the telemedicine services provided and all complaints about the distant site practitioner from patients, practitioners or staff at the Hospitals.

If the Hospitals have a pressing clinical need and a practitioner can supply that service through a telemedicine link, the Hospitals can evaluate the use of temporary privileges under Section VIII.F. above for this clinical situation.

Clinical privileging decisions encompass consideration of the appropriate use of telemedicine equipment by the telemedicine practitioner.

L. Medical History and Physical Exam ("H & P") Requirements.

(1) A medical history and physical examination shall be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, as described more fully in the medical staff rules and regulations.

(2) In cases in which the medical history and physical examination are completed within thirty (30) days before admission or registration, an *updated* examination of the patient, including any changes in the patient's condition, shall be completed and documented on the day of, but prior to surgery or a procedure requiring anesthesia services. ALL patients are required to have either a H&P, or an update to a valid H&P (as described in Deaconess Hospital Policy and Procedure 50-10S), to be performed, dated, and timed on the day of a procedure prior to the procedure; with exception of emergencies. If the medical history and physical examination is performed on the day of but prior to surgery or a procedure requiring anesthesia services, no update is required.

(3) The medical history and physical examination or updated examination must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified individual in accordance with state law and hospital policy.

(4) Certified physician assistants, certified nurse-midwives and nurse practitioners may write or dictate histories and physicals in patients' charts if granted such authority by the medical staff with the approval of the governing body. Histories and physicals performed by physician assistants, nurse-midwives and nurse practitioners must be countersigned by a physician. Histories and physicals may be performed by Podiatrists without countersignature by a physician so long as the patient does not remain in the hospital overnight.

ARTICLE VIII - APPOINTMENT AND REAPPOINTMENT

A. Application for Appointment.

(1) Criteria for Privileges

The medical staff shall make recommendations on all initial applications for privileges at the Hospitals which are based upon assessment of the applicant's current competence as documented by:

a. education;

b. training;

c. experience;

d. professional character;

e. ability to work with others in a cooperative manner in the provision of health care;

f. health;

g. professional liability coverage;

h. adverse medical malpractice experience;

i. query to the National Practitioner Data Bank;

j. timely and accurate completion of medical records.

k. criminal background check

The form, content and procedure for appointment and reappointment shall be prescribed in the medical staff rule and regulation entitled Credentialing Manual. In summary, applications for appointment to the medical staff or as an allied health provider shall be made to the Medical Staff Office where certain items of information are verified and additional information is collected. In the case of applicants to the medical staff, the Chief of the department for which the applicant is applying conducts an interview. Completed applications and supporting documents are reviewed by the Credentials Committee and forwarded with either

a positive or negative recommendation to the MEC. The MEC reviews all applications and recommendations forwarded to it by the Credentials Committee and will either forward with a favorable recommendation to the appropriate governing board or notify the applicant of a proposed unfavorable recommendation subject to the applicant's right to request a hearing and appeal (independent practitioners) or review (allied health providers who are not independent practitioners). Both the Credentials Committee and the MEC have the option of tabling an application for a period not to exceed thirty (30) days. Final decisions on applications are made by the applicable governing board.

(2) Burden of Providing Information

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, physical, mental and emotional health and other qualifications, and of resolving any doubts about such qualifications. He or she shall have the burden of providing evidence that all the statements made and information given on the application are factual and true. No consideration will be given to an application which is materially incomplete, as determined by the CEO of the Hospital or his/her designee.

(3) Statement of Release and Immunity from Liability

To the fullest extent permitted by law, the applicant releases from civil liabilities all authorized representatives of the Hospitals, including its medical staff and all personnel of peer review committees, for any acts, communications, reports, recommendations, or disclosures performed, made or received in good faith, concerning activities related to:

a. Application for appointment or clinical privileges, including temporary privileges;

b. Periodic reappraisals undertaken for reappointment or for expansion or limitation in clinical privileges;

c. Proceedings for suspension of clinical privileges or revocation of staff membership;

d. Summary suspension;

e. All actions affecting the privileges or status of a practitioner and the hearings and appellate review procedures relating thereto;

f. Other Hospital, departmental, or committee activities conducted under Hospital auspices relating to the quality of patient care or the professional conduct of a physician;

g. Release of information to other health care entities regarding the applicant's professional qualifications or competency.

(4) A practitioner or applicant for membership on the medical staff or for privileges as an allied health care provider who has been denied certain privileges by final action of the Hospital governing board may reapply for those privileges only after a two-year waiting period. The waiting period shall begin on the date of the Board's final action concerning the privileges.

(5) An application fee in an amount determined by the medical staff and approved by the Hospital governing boards shall accompany initial applications to the staff or for appointment as an allied health care provider.

B. Procedure for Appointment.

The procedure for appointment, as well as the various roles and procedures, shall be described in the medical staff rule and regulation entitled Credentialing Manual. Applicants for privileges (other than allied health care providers) shall be entitled to a fair hearing and appeal as set forth in the Fair Hearing Plan, Appendix A. Allied health care providers are covered by a separate process as described in Article VI, Chapter D, except to the extent that the allied health care provider has applied for or been granted privileges as an independent practitioner as covered by I.C. §§ 34-30-15-5(b) and 34-30-15-6(b).

C. Procedure for Reappointment.

Reappointment to the medical staff shall be based upon an assessment of the reapplicant's:

a. professional character;

b. ability to work with others in a cooperative manner in the provision of health care;

c. health;

d. professional liability coverage;

e. adverse medical malpractice experience;

f. query to the National Practitioner Data Bank;

g. timely and accurate completion of medical records;

h. utilization of facilities;

i. quality of care provided;

j. any incident/occurrence reports involving the practitioner;

k. continuing medical education appropriate to his or her specialty;

l. compliance with medical staff obligations, Bylaws, regulations, and hospital policies and procedures.

m. criminal background check

The procedure, application form and roles are addressed in the medical staff rule and regulation entitled Credentialing Manual. In summary, applications for reappointment to the medical staff or as an allied health care provider shall be made every three (3) years to the Medical Staff Office where information is reviewed. The process followed thereafter is the same as the process described for initial appointment under this Article, Section A.(1).

ARTICLE IX - CORRECTIVE ACTION FOR MEDICAL/DENTAL STAFF

A. Procedure.

(1) Requests for Corrective Action

Whenever the competence or professional conduct of any practitioner with clinical privileges (other than allied health care providers) is considered to be lower than the standards or aims of the medical staff, or to be disruptive to the operations of the Hospitals, or to make inefficient use of Hospital resources, corrective action against such practitioner may be requested by any member of the medical staff, by the CEO of a Hospital or his/her designee, or by any member of the governing boards. All requests for corrective action shall be in writing, shall be made to the MEC or governing boards, and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request. Requests by the governing boards for corrective action may be referred to the MEC for handling or may be handled under the Fair Hearing Plan as the board deems appropriate. It is expected that the boards will refer all matters of patient care, medical competence and medical ethics to the MEC. The following are intended to be representative of issues which may generate such a request for corrective action:

a. clinical competence;

b. care of a particular patient or patients;

c. violation of the Hospital Bylaws and policies, Medical Staff Bylaws, rules and regulations;

d. violations of professional ethics as outlined by the code of ethics which governs his or her professional organization;

e. violations of the Deaconess Health System Code of Conduct;

f. the mental, emotional or physical health of the practitioner (see, however, the option of referral to the Indiana State Medical Association (ISMA) Physician Assistance Program as appropriate);

g. conduct disruptive or detrimental to the operation of a Hospital and/or patient care;

h. unauthorized release of peer review information;

i. failure to comply with standards of quality medical care which recognize the efficient and effective utilization of Hospital resources;

j. corrective action of another health care entity;

k. failure to certify compliance with all state and federal statutes and regulations and hospital governing referrals, billing for services rendered to patients at the Hospitals, and conflicts of interest; failure to document compliance on request; and/or violation of such statutes, regulations or policies;

l. failure to conduct himself or herself at all times at the Hospitals without discrimination or harassment on the basis of race, color, religion, national origin, disability which with or without reasonable accommodation does not prevent the performance of the essential functions of a job or access to medical care, age, sex, sexual orientation, or any other unlawful or impermissible criterion.

(2) MEC Review of Request

a. The Chair of the MEC shall promptly notify the CEO of any of the Deaconess Hospitals at which the practitioner has privileges or his/her designee in writing of all requests for corrective action, and shall continue to keep the CEO of the Hospital or his/her designee fully informed of all action taken concerning the request.

b. After reviewing the request for corrective action, the MEC may determine that:

(1) the corrective action could not lead to a reduction or suspension of the practitioner's clinical privileges, in which case the MEC shall handle the matter;

(2) the corrective action could lead to a reduction or suspension of the practitioner's clinical privileges, in which case the MEC shall promptly appoint an investigating committee to investigate the matter under this Article, Chapter A, Section 3; or

(3) the action required is summary suspension, in which case the procedure under this Article, Chapter C shall be followed.

c. For any action, report, or recommendation of any investigating committee, hearing committee, or MEC, if the action, report, or recommendation is not unanimous, the members of the committee in the minority may submit a minority report.

d. When appointing members of investigating committees and hearing committees, the President of the Medical Staff, CEO of the Hospital, and/or Chair of the governing board, as applicable, shall take into consideration means of minimizing bias which could result from there being a small number of practitioners in the field of medicine of the affected practitioners, economic competition between groups of practitioners within the same field of practice or overlapping fields of practice. Economic competitors shall not be appointed to hearing committees. Appointment of practitioners who are not members of the medical staff may be considered.

(3) Investigating Committee Procedure

An investigating committee shall be appointed by the President of the Medical Staff or the President-Elect or the Past President if the other officers are unavailable or are involved in the proposed adverse action. The committee shall consist of at least three practitioners who are not direct economic competitors with the practitioner in question. Preference is given to active or senior members of the medical staff as members of the Committee, but the Medical Staff President may select qualified practitioners from outside of the Deaconess Hospital Medical Staff if necessary for an impartial investigation to occur. The investigating committee may be assisted by counsel at the Hospital's expense if the Hospital CEO or his/her designee deems assistance appropriate.

a. The practitioner shall have an opportunity for an interview with the investigating committee. At such interview, he or she shall be informed of the general nature of the questions directed to him or her, and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A record of such interview shall be made by the investigating committee. The affected practitioner may be accompanied at the interview by counsel at his or her own expense, but counsel shall not be allowed to speak unless requested to do so by the investigating committee.

b. Within thirty (30) days of its appointment, the investigating committee shall make a report of its investigation to the MEC, and shall include the record of its interview with the practitioner in its report.

(4) MEC Action

a. The MEC will, within ten (10) days of receipt of the report of the investigating committee:

(1) reject or modify the request for corrective action;

(2) issue a warning, a letter of admonition, or a letter of reprimand;

(3) impose terms of probation or a requirement for consultation;

(4) recommend reduction, suspension or revocation of clinical privileges;

(5) impose a punitive suspension not to exceed thirty (30) days in length;

(6) recommend the imposition of summary suspension as provided under this Article, Chapter C; and/or

(7) recommend that the practitioner's staff membership be suspended or revoked.

b. Any recommendation by the MEC for adverse action, as defined, shall entitle the affected practitioner to the procedural rights provided in Appendix A, Fair Hearing Plan.

c. Letters of admonition, warning or reprimand, imposition of required consultations, assistance or probation shall not be considered adverse action affecting privileges, shall not be reported to the Medical Licensing Board or to others making inquiry into a practitioner's privileges and shall not give rise to the procedural rights provided by Appendix A, Fair Hearing Plan.

B. Probation.

(1) Probation may be imposed on a practitioner who has clinical privileges. Probation is not punitive in nature, is not an adverse reflection of the practitioner's skills or character, and does not constitute an adverse action, as defined. Probation is required when more specific, first-hand observation is needed to evaluate a practitioner. Practitioners on probation will be observed by proctors assigned to them by the Credentials Committee or MEC with the advice of the chief of the department or departments involved. Proctors are to evaluate the medical care provided by the practitioner including, where appropriate, personal observation of diagnostic or surgical procedures, interpretation of diagnostic studies, and consultations. Proctors may base their reports in part on medical care which they have personally observed at other hospitals.

(2) Proctors are to provide detailed, personal observation of the skills and proficiency of the practitioner as the agents of the board in conducting peer review. The proctors' reports are confidential peer review material which shall not be part of or be mentioned in a patient's medical records. Proctors shall not be considered to be providing medical services to the patient being observed and shall not charge any patient for proctoring. Probationers agree as a condition of membership to cooperate fully with their proctors and to hold them harmless and release them absolutely from any claim or cause of action for all acts, omissions, and reports made in good faith while serving as proctors.

(3) Probation imposed for a problem in professional conduct is the same as a letter of warning and shall not be deemed an adverse action, but shall serve as notice to a practitioner that certain conduct will not be tolerated and that a repeat occurrence will result in a request for adverse action or, if appropriate, summary suspension.

C. Summary Suspension.

(1) The medical staff membership and/or clinical privileges of a practitioner may be suspended or limited, subject to subsequent notice and hearing as provided in these Bylaws, where the failure to take such an action may result in an imminent danger to the health of any individual. A summary suspension imposed in order to prevent the imminent risk of danger to the health of an individual shall continue until such time as the MEC may determine that the termination of the suspension would no longer pose such a risk. If the MEC votes to terminate such suspension within fourteen (14) days of its imposition, it shall be treated as an investigative suspension.

(2) An investigative suspension of the medical staff membership and/or clinical privileges of a practitioner may be imposed when a risk to patient care is judged to be material but not to amount to an imminent danger to the health of an individual or when such investigative suspension is necessary to prevent disruption of the operation of the Hospital. An investigative suspension shall extend no longer than fourteen (14) days during which time the MEC shall conduct an investigation or appoint an investigative committee to conduct an investigation to determine any need for a recommendation for adverse action. An investigative suspension may be continued beyond fourteen (14) days (a) if the practitioner agrees to such a continuance in order to complete an investigation, or (b) the MEC determines that lifting of the investigative suspension would result in imminent danger to the health of an individual.

(3) Either a summary suspension for imminent danger to the health of an individual or an investigative suspension may be summarily imposed upon a practitioner by a peer review committee composed of:

a. Any two of the following persons – the President of the Staff or Acting President, the Chief of the appropriate department, the CEO of a Hospital

at which the practitioner has privileges or his/her designee, and/or the Chair of the MEC, or

b. The MEC.

(4) The practitioner shall be given prompt written notice of the reasons for the summary suspension by the CEO of the Hospital or his/her designee. During the fourteen (14) day period after the imposition of the suspension, the suspension shall be an investigative suspension as defined in these Bylaws.

(5) During the investigative suspension, the MEC shall conduct an investigation to determine the need for a recommendation for adverse action. The suspended practitioner shall be entitled to request an interview with the MEC which shall take place during that fourteen-day period.

(6) During the investigative suspension, the MEC may recommend continuance, modification, or termination of the summary suspension. If the suspension is terminated within fourteen (14) days of its imposition without further recommendation for adverse action, no right to a hearing and appeal shall arise unless an investigative suspension has been imposed on the same practitioner more than twice in a six-month period.

(7) If the MEC determines to continue the summary suspension beyond fourteen days, or recommends other adverse action, the practitioner shall be given notice of the adverse action by certified mail, return receipt requested, from the President of the Hospital or his/her designee, in accordance with Appendix A, Fair Hearing Plan, Section 1(d). The practitioner shall have all of the rights to a hearing and appeal under the Fair Hearing Plan and shall be informed of his or her right to request an expedited hearing. The terms of the summary suspension as sustained or modified by the MEC shall remain in effect pending final decision by the Hospital governing board.

D. Automatic Suspension.

(1) Delinquent Patient Charts

a. A practitioner's patient charts shall be deemed delinquent if not completed by the period set from time to time in the Medical Staff Rules and Regulations and the Medical Staff Delinquent Chart Procedure. The Medical Records Department shall issue warning(s) to each practitioner who has one or more delinquent charts in accordance with the procedures set forth in the Medical Staff Delinquent Chart Procedure. If a practitioner fails to complete any delinquent charts within the time period specified, his or her Hospital privileges will be suspended in accordance with P&P 50-10S.

b. A practitioner whose privileges are suspended because of delinquent charts may not admit patients under the name of another practitioner.

c. Repeated automatic suspensions for failure to complete delinquent charts may result in monetary fines and referral to the MEC for possible corrective action under Article IX as set forth in the Medical Staff Delinquent Chart Procedure. They may also be taken into account under Section VIII.C.g. in determining whether to reappoint the reapplicant to the medical staff.

(2) Electronic Clinical Information System Training and Use

Any practitioner who is not in compliance with the electronic clinical information system training and use provisions of the Medical Staff Rules and Regulations after a reasonable opportunity to comply will be subject to automatic suspension.

(3) Expired or Suspended Licenses

a. Any expiration or suspension of a practitioner's license to practice his or her profession by his or her licensing board and/or any expiration or suspension of a practitioner's license to prescribe narcotic drugs shall automatically suspend the practitioner's Hospital privileges for the same period of time.

b. Any such suspension shall be submitted to the MEC and shall not be lifted until the MEC votes on whether or not to initiate its own corrective action.

(4) Failure to Have Insurance or Pay Surcharge

Any notification of cancellation or failure to renew professional liability insurance or of failure to pay the surcharge to qualify under the Indiana Medical Malpractice Act shall automatically suspend any practitioner's privileges in the Hospitals until such coverage is re-established.

(5) Failure to Complete Continuing Education

Automatic suspensions may also be imposed for failure to complete any required number of hours of continuing medical education.

(6) Failure to Pay Annual Dues

As set forth in Article IV of the Medical Staff Organization Manual, annual dues of the medical staff shall be established by the MEC. Practitioners whose dues are delinquent after the first quarter shall be notified by the Secretary-Treasurer. Practitioners whose dues are still delinquent at the end of the second quarter shall be automatically suspended from staff membership. Reinstatement shall be contingent upon payment of delinquent dues and approval of the Medical Staff Office.

(7) Failure to Pay Accrued Fines

Any accrued fines are due 45 days after the end of each quarter. Delinquent fines after 45 days will result in automatic suspension until paid in full.

(8) Failure to Obtain Required Vaccinations

If a physician or advanced practice provider chooses not to be vaccinated for COVID-19, influenza, or any other required vaccination, in accordance with hospital policy, health system policy or CMS guideline, without a medical or religious exemption being granted, then that physician or APP will be placed on automatic suspension.

(9) Effect of Automatic Suspension

Automatic suspensions are not deemed adverse action and do not give rise to a hearing or appeal, are imposed by notice to the affected practitioner by the Medical Records Department, MEC, or Hospital CEO or his/her designee, as appropriate, and are terminated by the practitioner's compliance with the involved requirement except as provided specifically otherwise. If a practitioner is under automatic suspension for one of the grounds specified above at the time his or her appointment expires, he or she is not eligible for reappointment.

ARTICLE X - IMMUNITY FROM LIABILITY

A. Condition of Practitioner's Application for or Exercise of Privileges.

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at the Hospitals:

(1) Any act, omission, communication, report, recommendation, or disclosure, with respect to any practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, or the orderly provision of health care therein, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

(2) Such privileges and immunity shall extend to the Hospital legal entities, members of the Hospital's medical staff, the Hospital governing boards, Presidents and CEOs, and their agents and or employees, personnel of peer review committees, and third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same.

For the purpose of this Article X, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Hospital governing boards or of the medical staff and all persons and organizations defined as "Personnel of a Peer Review Committee" by statute.

(3) There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, omission, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

(4) Such immunity shall apply to all acts, omissions, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

a. application for appointment or clinical privileges;

b. periodic reappraisals for appointment or clinical privileges;

c. corrective action, including summary suspension;

d. all actions affecting the privileges or status of a staff member and the hearings and appellate reviews relating thereto;

e. medical care evaluations;

f. utilization reviews;

g. other Hospital, departmental or committee activities related to quality of patient care and professional conduct; and

h. release or requesting of information to or from other medical institutions and/or individuals regarding the applicant's professional qualifications, mental, emotional and physical health, competency or professional conduct.

(5) The acts, omissions communications, reports, recommendations, and disclosures referred to in this Article X include any related to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly have an effect on patient care.

(6) Each practitioner shall, upon request of the Hospitals, execute releases in accordance with the tenor and import of this Article X in favor of the individuals and organizations specified in paragraph 2 above, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.

(7) The consents, authorizations, releases, rights, privileges and immunities provided in Article VIII of these Bylaws for the protection of the Hospitals, its medical staff, appropriate hospital officials and personnel, and third parties in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered in this Article X.

(8) Confidentiality and Immunity

a. Medical staff or committee minutes, files and records, including information regarding any member or applicant to this medical staff shall, to the fullest extent permitted by law, be confidential 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 staff's MEC or its designee. Unauthorized dissemination of peer review materials shall constitute grounds for corrective action.

b. Inasmuch as effective peer review and consideration of the qualifications of medical staff members and applications to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of discussions or deliberations of the medical staff committees, except in conjunction with other hospitals, professional society, or licensing authority, is outside appropriate standards of conduct for this medical staff and will be deemed disruptive to the operation of the Hospitals. If it is determined that such a breach has occurred, the MEC or governing boards may undertake such corrective action as they deem appropriate.

c. All persons involved in the credentialing process must be aware of the fact that unauthorized release of information obtained from the National Practitioners Data Bank is a violation of law which may subject the person to a civil money penalty of up to $11,000 per occurrence.

ARTICLE XI - DIVISIONS OF MEDICAL AND DENTAL STAFF

The medical staff shall be divided into Active, Senior, Courtesy, and Administrative staff. In addition to the four categories of members of the medical staff, there is one category of non-member affiliates—Honorary Affiliates.

A. Active Staff

The Active Staff shall consist of physicians and dentists who are privileged to admit and treat patients at the Hospitals and who maintain a practice within the service area of the Hospitals. Active staff are eligible to vote in meetings of the medical staff, hold elective office and serve on committees. Active Staff members are encouraged to attend the regular meetings of their department or section. All physicians and dentists on the Active Staff are required to pay dues, participate in the emergency service rotation and are encouraged to participate in the formal medical education programs of the staff.

B. Senior Staff

The Senior Medical Staff shall consist of physicians and dentists who have attained the age of sixty (60), or have served on the medical staff for a total of twenty-five (25) years,

or have been promoted for reasons of health. They maintain voting privileges as well as retain privileges to admit and treat patients. Senior Staff members shall not be eligible to hold elective office but may serve on committees at the discretion of the President of the Staff. The Senior Staff have no responsibility to rotate on the Emergency Room Call schedule for patients who have no physician and are not required to pay staff dues. They are urged to attend medical staff and their respective department meetings, but such attendance is not compulsory.

C. Courtesy Staff

The Courtesy Staff shall consist of members who are privileged to admit and treat patients at the Hospitals but are not eligible to vote or hold elective office or serve on committees. A Courtesy Staff member may admit or perform consultations or procedures on no more that twenty-five (25) patients per calendar year. All physicians and dentists on the Courtesy Staff are required to pay dues. Courtesy Staff members are urged to attend meetings of the medical staff as well as participate in the normal medical education programs, but these are not compulsory. The MEC shall determine, with the approval of the governing body, on a departmental or specialty basis whether members of the Courtesy Staff will be required to participate in the emergency service rotation.

D. Administrative Staff

Administrative staff consists of physician and dentist medical staff members who are retained solely to provide medical administrative functions within Deaconess Health System and do not perform any active patient care duties. Administrative staff may actively participate on Hospital committees and serve as voting members. Administrative staff are not subject to ongoing practice performance evaluation for the purpose of credentialing or re-credentialing. Administrative staff shall not be eligible to hold elected offices.

E. Locum Tenens

The Locum Tenens Staff shall consist of physicians and dentists who are privileged to admit and treat patients at the Hospitals. These members shall not have the rights of Active Staff members, may not vote, hold office, serve on any committees, and are not required to pay dues. All physicians and dentists on the Locum Tenens Staff are encouraged to participate in the emergency service rotation and in the formal medical education programs of the staff. A physician or dentist granted locum tenens privileges shall not be a member of the medical/dental staff, shall not have any of the rights or prerogatives of medical/dental staff membership, and shall abide by all bylaws, rules and regulations and policies of both the medical/dental staff and the Hospitals. Further, a physician or dentist granted locum tenens privileges shall not be entitled to the procedural rights afforded by the bylaws because of his/her inability to obtain locum tenens privileges, or because of any termination or suspension of such privileges. Locum Tenens appointments will be for a maximum of one (1) year and will automatically terminate unless an application for continuation of such privileges is submitted by the applicant at least 120 days prior to their termination. If a timely application of

continuance of such privileges is received, credentialing and privileging will be performed with respect to the application.

F. Honorary Affiliates

The Honorary Affiliates shall consist of physicians and dentists who do not actively practice at the Hospitals. These may be physicians who have retired from active practice or who are recognized for their noteworthy contribution to patient care and/or their long-standing service to the Hospital. Honorary Affiliates shall not be eligible to admit or treat patients, assist in surgery, serve as alternates, vote, hold office or serve on standing medical staff committees. The Honorary Affiliates have no emergency service responsibility and are not required to pay staff dues. They are urged to attend medical staff meetings, but such attendance is not compulsory.

G. Procedure for Leave of Absence

When a physician or dentist requests a leave of absence for a period of one (1) year or more for further education or military service or other reasons, he/she will forfeit all previously approved clinical privileges. On his or her return, he or she may request a change of staff status.

ARTICLE XII - COMMITTEES

The permanent committees of the Medical Staff Executive Council ("MEC") and the Credentials Committee are set out below. All other committees, either standing or ad hoc, are specified in the Medical Staff Organizational Manual.

A. Medical Staff Executive Council ("MEC")

(1) The MEC shall consist of the Immediate Past President, President, President-Elect, Secretary-Treasurer, six (6) at-large members elected by the Staff, the elected Chief of each of the departments listed in the Medical Staff Organization Manual, and the Director of the Family Medicine Residency Program. The CMO, Director of the Medical Staff Office and Chair of the Pharmacy and Therapeutics Committee shall be non-voting, ex-officio members. The CEOs of the Hospitals and/or their designees shall be advisory members without vote. The President-Elect of the staff shall serve as Chair.

(2) The duties of the MEC shall include but not be limited to the following:

a. to meet monthly;

b. to establish annually a quorum for the monthly meetings for the fiscal year;

c. to act for the staff as a whole and to coordinate the activities and general policies of the various departments;

d. to receive and act upon the reports of the departments and committees;

e. to implement the approved policies of the staff;

f. to advise the CEOs of the Hospitals in all matters pertaining to staff issues;

g. to act as the chief peer review committee in reviewing and recommending to the Hospital governing boards all matters relating to appointments and reappointments, clinical privileges, competence, professional conduct of practitioners, and corrective action;

h. to make reports and recommendations to the Hospital governing boards on matters concerning the quality of the overall medical care rendered to the patients in the Hospitals;

i. to monitor and advise the staff of the requirements to maintain Hospital accreditation;

j. to direct the use of medical staff funds;

k. to initiate and pursue corrective action and adverse action in accordance with these Bylaws and the Fair Hearing Plan, Appendix A; and

l. to recommend any changes in the medical staff governing documents to the Hospital governing boards.

(3) The committee shall claim all privileges and immunities afforded to it under the law as a peer review committee, and shall maintain the confidentiality of all peer review records and communications as privileged information.

B. Credentials Committee.

(1) The Credentials Committee shall consist of the three (3) Immediate Past Presidents of the Staff serving a two (2) year term, along with at least three (3) Medical Staff members from any specialty and one (1) allied health professional to be appointed by the President of the Medical Staff. Except for initial appointments, the medical staff and allied health professional members shall also serve two (2) year terms and may be reappointed to unlimited successive terms. The initial terms shall be staggered to ensure continuity and experience. The Senior Immediate Past President shall serve as Chair of the committee unless otherwise appointed by the President of the Medical Staff.

(2) The duties of the Credentials Committee shall include but not be limited to the following:

a. to meet as called by the Chair;

b. to review for recommendation to the MEC all applications and reapplications for privileges as members of the medical staff or as allied health care providers;

c. to review for recommendation to the MEC all requests for changes in privileges for practitioners or requesting a change in medical staff category;

d. to recommend to the MEC qualifications and criteria for clinical privileges;

e. to recommend to the MEC the method of delineating appropriate functions for physician extenders;

f. to recommend to the CEOs of the Hospitals those outpatient diagnostic procedures available to persons (other than medical staff members) who are qualified health care providers under the Indiana Medical Malpractice Act;

g. to serve as a review committee on denial, non-renewal, restriction, suspension or termination of any allied health care provider as provided by these Bylaws;

h. to act as a peer review committee in all of its functions, and thus claim all privileges and immunities of peer review committees under law and maintain the confidentiality of all peer review records and privileged information.

ARTICLE XIII - OFFICERS

The medical staff shall be organized into departments, standing and ad hoc committees as provided in the Medical Staff Organization Manual which shall be adopted as a rule and regulation of the medical staff subject to approval by the Hospital governing boards. Officers of the medical staff shall be: President, President- Elect, the Secretary/Treasurer, and the Immediate Past President, 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 responsibilities or purpose of the departments and of all standing committees except those described in Article XII shall be specified in the Medical Staff Organization Manual.

ARTICLE XIV - CLINICAL DEPARTMENTS

The business of the medical staff shall be carried out in meetings of the departments on a quarterly basis or as needed. If any department has fewer than three members, or all of its members are partners or shareholders in a single partnership or professional corporation, the MEC shall review the methods for conducting peer review within that service to seek effective performance of this duty.

ARTICLE XV - RULES AND REGULATIONS

The staff shall adopt rules and regulations which are separate from these Bylaws in order to facilitate the work of the medical staff and allied health care providers in the Hospitals. The MEC, in cooperation with the CEOs of the Hospitals, is empowered to institute or change rules by majority vote, subject to approval of the Hospitals' governing boards, and shall report same to the staff.

ARTICLE XVI - PARLIAMENTARY RULE

In all matters not covered by these Bylaws, this organization shall be governed by the current edition of the Standard Code of Parliamentary Procedure. However, technical failures to follow such rules shall not invalidate action taken at such a meeting.

ARTICLE XVII - GOVERNING BOARD CONSULTATION WITH MEDICAL STAFF PRESIDENT

As required by the Medicare Hospital Conditions of Participation (42 CFR § 482.12(a)(10)), the Board of Directors of Deaconess Hospital or the Quality Committee of the Board of Directors shall consult directly with the President of the unified Medical Staff or his or her designee periodically throughout the calendar year as needed but no less than twice a year on matters related to the quality of medical care provided to patients of the Hospitals.

"Direct consultation" means that the Board of Directors or Quality Committee meets with the President of the unified Medical Staff (already a member of the Board of Directors) or his or her designee either face-to-face or via a telecommunications system permitting immediate, synchronous communication.

The Board of Directors or Quality Committee is expected to schedule consultations based on a number of factors, including but not limited to: (1) the scope and complexity of hospital services offered; (2) specific patient populations served; (3) any issues of patient safety and quality of care that the Hospitals' quality assessment and performance improvement programs may periodically identify as needing the attention of the Board of Directors or Quality Committee in consultation with the Medical Staff; and (4) any requests from the President of the Medical Staff or his or her designee for timely consultation on matters of urgent concern regarding the quality of medical care provided to patients of the Hospitals.

The Board of Directors or Quality Committee will adopt policies and procedures addressing: (1) how it implements the requirement for periodic, direct consultation with the President of the Medical Staff or his or her designee; and (2) how the President of the Medical Staff or his or her designee gathers information about the concerns and views of members of the Medical Staff practicing at Deaconess Hospital or Deaconess Women's Hospital (the two separately certified hospitals) about quality of medical care provided at that hospital.

ARTICLE XVIII - TRIENNIAL REVIEW OF BYLAWS AND RULES AND REGULATIONS

As required by hospital licensing regulation 410 IAC 15-1.5-5 of the Indiana State Department of Health and the HFAP accreditation standards, the Bylaws Committee shall review these Bylaws and rules and regulations at least every three (3) years.

ARTICLE XIX - ADOPTION OF AMENDMENTS TO BYLAWS

These Bylaws may be amended by submitting the proposed amendment in writing to the Bylaws Committee for their consideration. After review and approval by the MEC, such proposals for amendment shall be mailed promptly to each voting member to be voted upon at the regular medical staff meeting the following month, or at a called meeting, or by mail ballot (including e-mail). The MEC shall select the method to be used for adoption. The MEC shall specify the time limit for returning ballots to the Medical Staff Office. The results of the balloting shall be reported at the next regular or special meeting of the medical staff.

The affirmative vote of two-thirds (2/3) of the voting membership present or who return ballots during the time period specified by the MEC shall be required for adoption. Amendments so made shall be effective when approved by the Hospitals' governing boards.

ARTICLE XX - AUTHORITY

It is recognized that the governing board is the governing authority of the corporate powers of each Hospital, as conferred by the Laws of the State of Indiana, and in the event these Bylaws and Rules conflict with said governing authority, said governing authority shall prevail.

Adopted: Medical Staff – October 21, 1973
Approved by the Board of Directors

Amendments adopted since October, 1973 have been incorporated in this document.

Amended: Medical Staff – December 15, 1982
Approved by the Board of Directors – December 20, 1982

Amended: Medical Staff – January 16, 1985
Approved by the Board of Directors – January 28, 1985

Amended: Medical Staff – March 20, 1985
Approved by the Board of Directors – March 25, 1985

Amended: Medical Staff – June 19, 1985
Approved by the Board of Directors – June 24, 1985

Amended: Medical Staff – September 18, 1985
Approved by the Board of Directors – October 28, 1985

Amended: Medical Staff – January 20, 1993
Approved by the Board of Directors – January 25, 1993

Amended: Medical Staff – July 17, 1996
Approved by the Board of Directors – August 19, 1996

Amended: Medical Staff – March 18, 1999
Approved by the Board of Directors – April 19, 1999

Amended: Medical Staff – May 9, 2001
Approved by the Board of Directors – May 15, 2001

Amended: Medical Staff – October 31, 2001
Approved by the Board of Directors – November 19, 2001

Amended: Medical Staff – March 20, 2002
Approved by the Board of Directors – April 15, 2002

Amended: Medical Staff - May 7, 2004
Approved by the Board of Directors - May 17, 2004

Amended: Medical Staff – June 20, 2007
Approved by the Board of Directors – August 20, 2007

Amended: Medical Staff – September 19, 2007
Approved Board of Directors – August 20, 2007

Amended: Medical Staff – March 23, 2011
Approved Deaconess Hospital Board of Directors – March 28, 2011
Approved Women's Hospital Board of Managers – April 26, 2011

Amended: Medical Staff – June 15, 2011
Approved Deaconess Hospital Board of Directors – June 27, 2011
Approved Women's Hospital Board of Managers – October 25, 2011

Amended: Medical Staff – August 30, 2013
Approved Deaconess Hospital Board of Directors – September 23, 2013
Approved Women's Hospital Board of Managers – September 24, 2013

Amended: Medical Staff – February 13, 2015
Approved Deaconess Hospital Board of Directors – February 23, 2015
Approved Women's Hospital Board of Managers – February 24, 2015

Amended: Medical Staff – March 23, 2018
Approved Deaconess Hospital Board of Directors –February 26, 2018
Approved Women's Hospital Board of Managers – February 27, 2018

Amended: Medical Staff – April 15, 2019
Approved Deaconess Hospital Board of Directors –April 22, 2019
Approved Women's Hospital Board of Managers – April 23, 2019

Amended: Medical Staff – October 9, 2021
Approved Deaconess Hospital Board of Directors – October 28, 2021
Approved Women's Hospital Board of Managers – December 14, 2021

Amended: Medical Staff – January 19, 2023
Approved Deaconess Hospital Board of Directors – January 26, 2023
Approved Women's Hospital Board of Managers – February 28, 2023

Amended: Medical Staff – August 2, 2023
Approved Deaconess Hospital Board of Directors – July 24, 2023
Approved Women's Hospital Board of Managers – August 22, 2023

Amended: Medical Staff – November 14, 2023
Approved Deaconess Hospital Board of Directors – November 17, 2023
Approved Women's Hospital Board of Managers – November 28, 2023

Amended: Medical Staff – May 16, 2024
Approved Deaconess Hospital Board of Directors – June 20, 2024
Approved Women's Hospital Board of Managers – August 29, 2024

Amended: Medical Staff – August 23, 2024
Approved Deaconess Hospital Board of Directors – August 23, 2024
Approved Women's Hospital Board of Managers – August 29, 2024

Amended: Medical Staff – January 24, 2025
Approved Deaconess Hospital Board of Directors – January 12, 2025
Approved Women's Hospital Board of Managers – January 28, 2025

APPENDIX "A"

FAIR HEARING PLAN

Preamble

The Hospital governing boards and medical staff of Deaconess Hospital have constituted themselves as peer review committees under the Indiana Peer Review Act, I.C. §34-30-15-1 et seq., and as professional review bodies under the Health Care Quality Improvement Act of 1986, and claim all of the privileges and immunities thereunder. It is the goal of Appendix A of these Bylaws to secure a fair hearing for any applicant for or holder of clinical privileges who has a right to a hearing or appeal under these Bylaws based on professional review activity, conducted in an orderly fashion with adequate notice and an opportunity to be heard, and to test the validity of opposing witnesses and evidence with the assistance of counsel. The appellate review provided for herein is afforded to examine the basic fairness of the hearing, the existence of evidence supporting the recommendation, and the propriety of the recommendation. The governing boards and medical staff reserve the right to afford such a fair hearing and appeal by following the procedures in this appendix or any other procedures which are essentially fair and protect the interests of the affected practitioner.

The right to a hearing and appeal may arise from recommendations for adverse action, as defined, made by the MEC on applications for privileges or reapplications for privileges, or as the result of requests for corrective action, or by a Hospital governing board with respect to a practitioner who has privileges at such Hospital. The Hospital governing boards may recommend adverse action on privileges not previously based on an adverse recommendation of the medical staff or may initiate corrective action on its own with or without reference to the medical staff. When an adverse action is first initiated by a Hospital board, it may refer the matter to the medical staff by having the Hospital CEO request corrective action to the MEC or it may appoint a Hearing Committee on its own. When the matter concerns questions of medical training or judgment, as opposed, for example, to disruptive behavior, the Hospital Board will either request corrective action of the MEC or appoint a Hearing Committee composed of a majority of physicians.

Section 1. Right to Hearing and to Appellate Review

a. When any practitioner receives notice of a recommendation of the MEC, or Hospital governing board, that, if ratified by decision of the Hospital governing board, will adversely affect his or her appointment to or status as a member of the medical staff or his or her exercise of clinical privileges, he or she shall be entitled to a hearing before a Hearing Committee appointed by the Hospital CEO in consultation with the President of the Medical Staff and the Chair of the MEC. If the recommendation of the MEC or Hospital governing board following such hearing is still adverse to the affected practitioner, he or she shall then be entitled to an appellate review by the Hospital governing board, before the Hospital governing board makes a final decision on the matter.

b. When any practitioner receives notice of a decision by the Hospital governing board that will affect his or her appointment to or status as a member of the medical staff or his or her exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the MEC with respect to which he or she was entitled to a hearing, then he or she shall be entitled to a hearing by a committee appointed by the Hospital governing board, and if such hearing does not result in a recommendation favorable to the practitioner, to an appellate review by the Hospital governing board, before the Hospital governing board makes a final decision on the matter.

c. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Appendix to assure that the affected practitioner is accorded all rights to which he or she is entitled or other procedures which are essentially fair and protect the interest of the affected practitioner as specified in the Health Care Quality Improvement Act of 1986 and Indiana Code §34-30-15-1 et seq.

d. Notice of Proposed Adverse Action

1. In all cases in which a practitioner has been recommended by the MEC or the Hospital governing board initially for adverse action, the Hospital CEO shall be responsible for giving prompt written Notice (within ten (10) days) to the affected practitioner of the proposed adverse action and of the practitioner's rights to a hearing or an appellate review, by certified mail, return receipt requested, or by personal delivery. Such Notice shall contain the following information:

a. That a professional review action has been proposed to be taken concerning the practitioner;
b. The reasons for the proposed action including representative records and/or incident or committee reports if known at the time;
c. That any hearing must be requested within thirty (30) days;
d. That an expedited hearing date may be requested by a practitioner under suspension; and
e. A summary of the practitioner's rights as provided herein.

Section 2. Request for Hearing

a. In all cases in which any practitioner has been recommended for adverse action, the practitioner may, within thirty (30) days of receipt of notice as provided under Section 1(d), request in writing a hearing before a Hearing Committee.

b. The failure of a practitioner to request a hearing to which he or she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his or her right to such hearing and to any appellate review to which he or she might otherwise have been entitled on the matter. The failure of a practitioner to request an appellate review to which he or she is entitled by these

Bylaws within the time and in the manner herein provided shall be deemed a waiver of his or her right to such appellate review on the matter.

c. When the waived hearing or appellate review relates to an adverse recommendation of the MEC or of a Hearing Committee appointed by the Hospital governing board, the same shall thereupon become and remain effective against the practitioner pending the Hospital governing board's decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Hospital governing board, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the Hospital governing board provided in Section 7 of this Appendix A. In either of such events, the CEO of the Hospital shall promptly notify the affected practitioner of his or her status by certified mail, return receipt requested.

Section 3. Notice of Hearing

a. Within ten (10) days after receipt of a request for hearing from a practitioner entitled to the same, the Hospital CEO shall schedule and arrange for such a hearing and shall notify the practitioner of the time, place and date so scheduled by certified mail, return receipt requested. The hearing date shall be not less than thirty (30) days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension which is then in effect and who requests an expedited hearing shall be held as soon as arrangements may reasonably be made, but not later than fifteen (15) days from the date of receipt of such practitioner's request for hearing.

b. The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision, and a list of witnesses (if any) who are expected to testify at the hearing on behalf of the professional review committee or Hospital.

c. The presiding member of the Hearing Committee shall appoint a reasonable date, time and place for the exchange of witness lists and copies of exhibits by both sides. Any witness not then listed and any exhibit not provided may in the discretion of the committee or hearing officer be excluded from the hearing.

d. All material contained in a practitioner's credentials and/or personal file considered in making the recommendation for adverse action shall be part of the hearing record, and the practitioner shall have the right to have a copy of all such material in advance of the hearing.

Section 4. Appointment of Hearing Committee

a. The Committee shall be appointed by the Hospital CEO and shall be comprised of not less than three (3) physicians not in direct economic competition with the affected practitioner and who have had no prior involvement with the matter. One

of the members so appointed shall be designated as Chair. No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this Hearing Committee. Only physicians and dentists may serve on such a Hearing Committee. The members of the Committee need not be members of the Hospital medical staff.

b. When a hearing relates to an adverse decision of a Hospital governing board that is contrary to the recommendation of the MEC or which is not based on a previous recommendation of the medical staff, the Hospital CEO may appoint a Hearing Committee to conduct such hearing and shall designate one of the members of this committee as Chair.

c. A Hearing Committee may be represented and advised by an attorney hired at the expense of Deaconess Hospital to advise the members on procedure and law and to assist it in drafting findings and recommendations voted by members of the committee.

Section 5. Conduct of Hearing

a. There shall be at least a majority of the members of a Hearing Committee present when the hearing takes place, and no member may vote by proxy.

b. An accurate record of the hearing must be kept. The mechanism shall be established by the Hearing Committee, and may be accomplished by use of a court reporter, or electronic recording unit and detailed transcription.

c. The personal presence of the practitioner for whom the hearing has been scheduled shall be required unless he or she has waived such appearance and has been deemed to have accepted the adverse recommendation/decision involved.

d. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Chair of the Hearing Committee. Granting of such postponements shall only be for good cause shown and in the sole discretion of the Chair.

e. The affected practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the medical staff in good standing or by a member of his or her local professional society, or by an attorney at his or her own expense.

f. The Chair of the Hearing Committee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

g. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs

shall be considered, regardless of the existence of any common law or statutory rule that might make evidence inadmissible over objection in a civil or criminal action. However, reasonable efforts shall be made to avoid hearsay testimony, it being understood that such testimony is less favored than direct evidence, the intent of this hearing being that fairness prevail. The practitioner for whom the hearing is being held and the representative advocating adverse action shall, prior to, during or after the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

h. The affected practitioner and the representative advocating the proposed adverse action shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence, to submit a written statement at the close of the evidence, to have a copy of the record of the proceedings upon payment of any reasonable charge associated with the preparation thereof, and to receive a copy of the written findings and recommendations of the Hearing Committee. If the practitioner does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

i. It is the burden of the representative of the MEC or governing board taking or recommending adverse action to demonstrate that the adverse action taken or recommended is supported by a preponderance of the evidence and was taken or recommended in substantial compliance with the Medical Staff Bylaws.

j. The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. All members sitting on a Hearing Committee, representing the staff or Hospital governing board and their counsel, shall be deemed to be the agents of the board in conducting peer review for the benefit of the governing board. All persons participating in or communicating to such a Hearing Committee shall be immune from any cause of action for any actions done in good faith.

k. The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened. The Hearing Committee may recess the hearing at its conclusion until a transcript can be provided.

l. Within fifteen (15) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the MEC or to the Hospital governing board, whichever initiated the recommended adverse

action. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the MEC or decision of the Hospital governing board.

m. The MEC or Hospital governing board, whichever originated the proposed adverse action, shall receive the report and recommendations of the Hearing Committee, a complete set of all exhibits admitted into evidence, all written memoranda submitted by either party, and the transcript or other record of the testimony. The MEC or Hospital governing board shall give due deference to the findings of fact of the Hearing Committee but shall not be bound thereby. The MEC or Hospital governing board may make additional or other findings of fact as either body deems supported by the record before it and may accept, modify, or reject the recommendations of the Hearing Committee as it deems appropriate as supported by the record before it. The MEC or Hospital governing board shall state its report and recommendations in writing and forward copies to the affected practitioner and the representative advocating adverse action, but neither shall take further action thereon until the affected practitioner has exercised or has been deemed to have waived his or her right of appeal.

n. If the report recommends no adverse action for the practitioner, the report shall be sent to the Hospital governing board for its consideration and action. If the report of the MEC or Hospital governing board recommends adverse action for the practitioner, the Hospital CEO shall be responsible for giving prompt written notice (within 10 days) to the affected practitioner of the adverse decision and of the practitioner's right to an appellate review, by certified mail, return receipt requested or by personal delivery. Such notice shall contain the following information:

1. that an adverse recommendation had been made by the MEC or Hospital governing board based on the record of the Hearing Committee and the substance of that recommendation;

2. the reasons given by the MEC or Hospital governing board for the adverse recommendation;

3. that an appellate review must be requested in writing within seven (7) days;

4. that an expedited appellate review date may be requested by a practitioner under suspension; and

5. a summary of the practitioner's rights as provided herein.

Section 6. Appeal to the Governing Board

a. Within seven (7) days after an affected practitioner receives notice of an adverse recommendation or decision made or adhered to after a hearing as above provided, he or she may, by written notice to the governing board of any Hospital

at which the practitioner has privileges, delivered through the Hospital CEO by certified mail, return receipt requested, request an appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

b. If such appellate review is not requested within seven (7) days, the affected practitioner shall be deemed to have waived his or her right to the same, and to have accepted such adverse recommendation or decision and the same shall become effective immediately as provided in Section 2 of this Appendix A.

c. Within ten (10) days after receipt of such notice of request for appellate review, the Hospital governing board shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall through the Hospital CEO, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same. The date of the appellate review shall not be more than thirty (30) days from the date of receipt of the notice of request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than fifteen (15) days from the date of receipt of such notice.

d. The appellate review shall be conducted by the Hospital governing board or by a duly appointed appellate review committee of the governing board of not less than five (5) members.

e. The affected practitioner shall have access to the report and record (and transcription, if any) of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him or her. An opportunity to submit a written statement in his or her own behalf, in which those factual and procedural matters with which he or she disagrees, and his or her reasons for such disagreement, shall be provided. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Hospital governing board through the Hospital CEO by certified mail, return receipt requested, at least three (3) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the MEC or by the Chair of the Hearing Committee, and if submitted, the Hospital CEO shall provide a copy thereof to the practitioner at least three (3) days prior to the date of such appellate review by certified mail, return receipt requested.

f. The Hospital governing board or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statements submitted pursuant to subparagraph (e) of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not unreasonable.

If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation, and shall answer questions put to him or her by any member of the appellate review body. The MEC or the governing board, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him or her by any member of the appellate review body.

g. New or additional matters not raised during the original hearing or in the Hearing Committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the governing board or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

h. If the appellate review is conducted by a committee of the governing board, such committee shall, within ten (10) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the governing board affirm, modify or reverse the prior recommendation or decision, or refer the matter back to the Hearing Committee for further review and recommendation within fifteen (15) days. Such referral may include a request that the Hearing Committee arrange for a further hearing to resolve the disputed issues. Within ten (10) days after receipt of such recommendation after referral, the committee shall make its recommendation to the governing board as above provided.

i. Upon appeal, the governing board shall receive the report and recommendations of the Hearing Committee, a complete set of all exhibits admitted into evidence, all written memoranda submitted by either party, and the transcript or other record of the testimony. The governing board shall give due deference to the findings of fact of the Hearing Committee but shall not be bound thereby. The governing board may make additional or other findings of fact and may accept, modify, or reject the recommendations of the Hearing Committee as it deems appropriate as supported by the record before it.

j. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the governing board may be taken by a committee of the governing board duly authorized to act.

Section 7. Final Decision by Governing Board

a. Within thirty (30) days after the conclusion of the appellate review, the governing board shall make its final decision in the matter and shall send notice thereof to the MEC, and, through the Hospital CEO, to the affected practitioner, by certified mail, return receipt requested. This decision shall be immediately effective and final, and shall not be subject to further hearing or appellate review.

b. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the MEC, or by the Hospital governing board, or by a duly authorized committee of the governing board, or by both.

c. As required by the Health Care Quality Improvement Act of 1986 and Indiana Code § 16-21-2-6, the Hospital CEO shall report adverse actions to the Indiana Medical Licensing Board and the National Practitioner Data Bank within the time period required, as well as any voluntary resignation or surrender of clinical privileges by a practitioner after a request for corrective action has been made to the MEC or governing boards and the matter is under investigation in accordance with the procedures set forth in Article IX and the Fair Hearing Plan.

d. The Hospital CEO is responsible for filing any corrections or modifications of notices of adverse actions.

e. As a condition of applying for or holding any privileges at these Hospitals, a practitioner binds himself or herself to exhaust all administrative remedies set forth in this Fair Hearing Plan before seeking any form of administrative or judicial review of the matter.

Adopted: Medical Staff – January 20, 1993
Approved Board of Directors – January 25, 1993

Amended: Medical Staff – June 20, 2007
Approved Board of Directors – August 20, 2007

Amended: Medical Staff – March 23, 2011
Approved Deaconess Hospital Board of Directors – March 28, 2011
Approved Women's Hospital Board of Managers – April 26, 2011

Amended: Medical Staff- August 18, 2017
Approved Deaconess Hospital Board of Directors- August 28, 2017
Approved Women's Hospital Board of Managers- August 22, 2017

APPENDIX “B”

CODES OF ETHICS

Reference Websites

American Medical Association-
http://www.ama-assn.org/ama/pub/category/13337.html

American Osteopathic Association-
http://www.osteopathic.org/index.cfm?PageID=aoa_ethics

American College of Surgeons-
http://www.facs.org/fellows-info/statements/stonprin.html

American Dental Association-
http://www.ada.org/prof/prac/law/code/index.asp

Deaconess Health System Code of Conduct, contained in the Medical Staff General Rules and Regulations