BYLAWS

Medical Staff of Gibson General Hospital

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BYLAWS

Medical Staff of Gibson General Hospital

Princeton, Indiana

Preamble

These bylaws, which originate with the Medical Staff, are adopted in order to provide for the organization of the Medical Staff of Gibson General Hospital and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities to the Board of Directors for the clinical and scientific work of the hospital, advice regarding professional matters and policies to the Board of Directors, reviewing the professional practices in the Hospital for the purpose of reducing morbidity and mortality and the improvement of the care of patients in the hospital. The Board of Directors of the Hospital shall be the supreme authority in the Hospital responsible for: the management, operation, functioning and control of the Hospital; the appointment and re-appointment of the members of the Medical Staff and the assignment of privileges in the hospital with the advice and recommendations of the Medical Staff, consistent with the individual's training, experience and other qualification; and establishing requirements for initial and subsequent appointments to and continued service on the Hospital's Medical Staff and the assignment of privileges in the hospital, including, but not limited to, such requirements as set forth in I.G. 16-10-6.5.

Definitions

1. Hospital means Gibson General Hospital, Inc.

2. Board of Directors or Board or Board of Trustees means the governing body of the hospital, referred to in the articles of incorporation as the board of trustees.

3. Administrator means the person appointed by the board of directors to act on it's behalf in the overall management of the hospital.

4. Medical Staff or Staff Member means those physicians licensed to practice medicine, osteopathic Medicine, podiatric medicine, or dentistry in the State of Indiana who have been granted recognition as members of the Medical Staff pursuant to the terms of these bylaws.

5. Medical Executive or Executive Committee means the Executive Committee of the Medical Staff which shall constitute the governing body of the Medical Staff pursuant to the terms of these bylaws.

6. Medical Staff Year means the period from January 1 through December 31.

7. Chief of Staff means the chief officer of the Medical Staff elected by members of the Medical Staff.

The following definitions (9-18), which are taken from the Federal Health Care Quality Improvement Act of 1986, shall also apply throughout these bylaws:

8. Physician means a doctor or osteopathy or a doctor of dental surgery or medical dentistry, legally authorized to practice medicine and surgery or dentistry by the State of Indiana and shall also for the purpose of participation as a member of the medical staff, include persons who are licensed by the Medical Licensing Board of Indiana to practice podiatric medicine and who hold a D.P.M. degree issued by a podiatric school approved by the Medical Licensing Board of Indiana.

9. Clinical Privileges includes privileges, membership on the medical staff as granted by the bylaws and the other circumstances pertaining to the furnishing of medical care under which a physician or other allied health care provider is permitted to furnish such care by the Hospital.

10. Allied Health Care Provider or Provider means an individual (other than a physician, a dentist or a podiatrist) who is licensed or otherwise authorized by the State of Indiana to provide health care services. Such individuals are not members of the medical staff but may be granted clinical privileges in the hospital in accordance with these bylaws, but are not entitled to the notice and hearing requirements afforded to physicians under the Federal Health Care Quality Improvement Act of 1986 and pursuant to these bylaws, unless otherwise specifically provided for in these bylaws.

11. Professional Review Action means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence of professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. An action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on those items set forth in 42 U.S.C. 11151(9), the HealthCare Quality Improvement Act of 1986.

12. Professional Review Activity means an activity of a health care entity, including the hospital or any of its professional review bodies, agents or employees, with respect to an individual physician to determine whether the physician may have clinical privileges with respect to, or membership in, the hospital; to determine the scope or conditions of such privileges or membership; or to change or modify such privileges or membership.

13. Professional Review Body means the hospital and the board of directors or any committee of the hospital and the hospital's agents and employees, which conduct professional review activity, and includes the medical staff and any committee of the medical staff of the hospital when assisting the board of directors in a professional review activity.

14. Health Care Entity means a hospital licensed to provide health care services by the State in which it is located, an entity (including a health maintenance organization or group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care, and a professional society (or committee thereof) of physicians or other allied health care provider that follows a formal peer review process for the purpose of furthering quality health care.

16. Adversely Affecting includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in the hospital.

16. Medical Malpractice Action or claim means a written claim or demand for payment based on the furnishing (or failure to furnish) health care services by a physician, allied health care provider or a health care entity or its employees or agents, and includes the filing of a cause of action, based on the law of tort, brought in any state or the United States seeking monetary damages.

17. Board of Medical Examiners or State Licensing Board in Indiana means the medical licensing board of Indiana which is primarily responsible for the licensing of the physician or any other agency in Indiana which is primarily responsible for the licensing of the dentist or any allied health care provider to furnish health care services and also includes a subdivision of such agency or board.

18. Administrative Action means any determination, recommendation or action taken by or on behalf of the MEC or Board, or their respective designees, that is made or taken without a prior hearing for reasons related to objective administrative circumstances, as set forth in these Bylaws. Administrative actions are not professional review actions.

19. Focused Professional Practice Evaluation or "FPPE" refers to the peer review evaluation, for privilege-specific competency, of applicants seeking clinical privileges at the Hospital and of practitioners who have requested to receive new or additional clinical privileges; and also refers to the peer review evaluation of practitioners where specific performance-related concerns implicating patient safety and/or quality of care are identified.

20. Ongoing Professional Practice Evaluation or "OPPE" means the systematic and ongoing peer review process used to evaluate and confirm the current competency of those practitioners with clinical privileges at the Hospital.

ARTICLE I

NAME

The name of this organization shall be the Medical Staff of the Gibson General Hospital.

ARTICLE II

Membership

2.1 Nature of Membership

No physician, including those in a medical administrative position by virtue of a contract or employment with the hospital, shall admit or provide medical or health-related services to patients in the hospital unless they are a member of the medical staff or has been granted temporary privileges in accordance with the procedures set forth in these bylaws. Appointment to the medical staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

2.2 Qualifications for Membership

2.2-1 General Qualifications

Only physicians who shall be deemed to possess basic qualifications for membership in the medical staff, except for the honorary staff category in which case these criteria shall only apply as deemed individually applicable, who are recommended by the medical staff and approved by the board, and who meet the following are eligible for membership in the medical staff.

(a) Document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the medical staff and the board that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

(b) Agree (1) to adhere to the ethics of their profession, (2) to work cooperatively and effectively communicate with others so as not to affect patient care adversely, (3) to perform patient care and related duties in a manner that is not disruptive to the delivery of quality medical care, 4) to efficiently and effectively utilize hospital resources, and (5) to participate in and properly discharge those responsibilities determined by the medical staff; and

(c) Submit proof that they are qualified as a health care provider under Indiana's medical malpractice acts.

(d) An applicant must be free of physical and mental impairments which would prohibit the applicant from practicing, with or without reasonable accommodation, the essential functions of the applicant's profession.

2.2-2 Particular Qualifications

(a) Physicians: a M.D. or D.O. applicant for membership in the medical staff, except for the honorary staff, must hold a M.D. or D.O. degree issued by a medical or osteopathic school approved at the time of the issuance of such degree by the Medical Licensing Board of Indiana and must hold a valid unsuspended license to practice medicine issued by the Medical Licensing Board of Indiana. Physicians who have had limitations or restrictions placed on their licenses by appropriate legal authorities may continue to hold membership on the medical staff, if recommended by the medical staff and approved by the Board.

(b) Dentists: a dentist applicant for membership in the medical staff must hold a D.D.S. or D.M.D. degree issued by a dental school approved at the time of the issuance of such degree by the Indiana State Board of Dental Examiners and must hold a valid and unsuspended license to practice dentistry issued by the Indiana State Board of Dental Examiners.

(c) Podiatrist: a podiatrist applicant for membership in the medical staff must hold a D.P.M. degree issued by a podiatric school approved by the Medical Licensing Board of Indiana at the time of the issuance of such degree and must hold a currently valid license to practice podiatric medicine issued by the Medical Licensing Board of Indiana without limitation other than the podiatrist is limited in their practice to the diagnosis or medical, surgical, and mechanical treatment of aliments of the human foot and with the further proviso that the prerogatives of a podiatrist shall be:

(1) to co-admit patients under the name of an active M.D. or D.O. member of the active staff who shall assume the overall responsibility for the care and medical welfare of the patient; the M.D. or D.O. will perform the history and physical on all inpatients; the podiatrist will be responsible for the podiatric history and physical;
(2) to write orders and prescribe medications within the limits of his/her licensure so long as they apply to a primary disease or disability of the foot and ankle;
(3) to be responsible for the admitting and final diagnosis and operative procedure on matters relating to the foot and ankle;
(4) to be responsible on outpatient cases to perform the history and physical when the patient is determined to be ASA class I or II; if the patient is determined to be ASA class III or beyond, an M.D. or D.O. will be responsible to complete the history and physical; the podiatrist will be responsible for the podiatric history and physical;
(5) to be responsible for the discharge summary if the co-admitter, M.D. or D.O. so desires and the M.D. or D.O. co-signs to indicate their concurrence and supplies any additional information as desired;
(6) otherwise and subject only to these limitations and conditions, podiatrists are members of the medical staff and shall enjoy all of the privileges including the procedural rights afforded under article VIII of M.D, D.O. or dentists' members of the medical staff.

2.2-3 Board Certification Requirements

(a) An applicant who submits an application for initial appointment to the Medical Staff on or after April 1, 2016, must be certified by a recognized Board (as defined in paragraph [b] of this section) in applicant's primary specialty or subspecialty as of the date of

applicant's application for initial appointment to the Medical Staff. The board certification requirements do not apply to Honorary staff members.

If applicant is not board certified as of that date, applicant may submit their application subject to the requirement that applicant must obtain board certification within five (5) years from the date applicant is eligible to sit for board certification examination or within five (5) years of applicant's initial appointment to the Medical Staff, whichever is earlier.

Once certified by a recognized Board, the Medical Staff member must remain certified as a condition for Medical Staff membership. If Medical Staff member's board certification lapses for any reason, applicant will have a grace period of three years to regain board certification.

Notwithstanding the requirements set forth above with respect to board certification, it is acknowledged that Gibson General Hospital may infrequently encounter a compelling patient care or community need that necessitates consideration of an applicant to the Medical Staff who is not certified by a recognized Board. In such circumstances, the Board of Trustees of Gibson General Hospital, in the exercise of its discretion and upon the recommendation of the Medical Executive Committee, may waive the requirement of board certification if such waiver is found by the Board to be essential to maintaining quality patient care.

(b) A Recognized Board is a board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Physician Specialties (APP), the Royal College of Physicians & Surgeons of Canada, the American Board of Podiatric Surgery (ABPS), the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM), the American Council of Certified Podiatric Physicians and Surgeons (ACCPPS), American Board of Oral and Maxillofacial Surgery, or other Boards approved by the Board of Trustees from time to time.

(c) The failure of a Medical Staff member to comply with these requirements shall result in either the revocation of his/her medical staff membership or the denial of their application for reappointment. Revocation of medical staff membership or denial of an application for reappointment for failure to comply with the applicable requirements of this section shall not be deemed an Adverse Action invoking a right to a hearing under the Fair Hearing Plan of the Medical Staff Policies & Procedures.

2.3 Effect of Other Affiliations

No person shall be entitled to membership in the medical staff merely because he holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care entity.

2.4 Nondiscrimination

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, religion, color, national origin, or mental or physical

disability. Any and all disputes, claims, or controversies arising out of an alleged violation of this nondiscrimination policy shall be subject to the fair hearing process provided for in article viii of these bylaws and that process shall be considered to be binding arbitration within the meaning of title 9 of the United States code; with the further proviso, however, that the physician alleging violation of the nondiscrimination clause may request that the board appoint members of the hearing committee from physicians or providers who are not members of the medical staff.

2.5 Basic responsibilities of Medical Staff Membership

Basic responsibilities of Medical Staff membership and the ongoing responsibilities of each member of the medical staff shall include:

(a) Providing patients with the quality of care meeting the professional standards of this Hospital, which shall comply with the medical professional standards of exercising reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments and current professional theory as practiced by physicians in the same or similar locality;

(b) Abiding by applicable hospital bylaws, rules, regulations, policies, and the Hospital's Corporate Compliance Plan.

(c) Preparing and completing in a timely fashion medical records for all the patients to whom the member provides care in the hospital;

(d) A medical history and physical examination are completed and in the medical record on each inpatient within 24 hours of admission. This time frame applies for weekend, holiday, and weekday admissions. A durable, legible original or reproduction of a medical history and a completed physical assessment, obtained in the office of a licensed independent provider, completed within 30 days before admission, is acceptable provided that it is accompanied by an update performed within 24 hours of admission.

(e) The medical staff member will have the responsibility of completing the discharge summary within seven (7) days, and the remainder of the patient record within thirty (30) days following the date of discharge of the patient.

(f) It is the responsibility of the medical staff member to review and complete his/ her medical records and complete them within the time frame specified by the Medical Staff Bylaws and Regulations. A practitioner's medical records which are incomplete shall be considered delinquent.

(g) The Medical Records Department shall issue warning(s) to any practitioner who has one or more delinquent charts in accordance with the Medical Staff delinquent chart procedure. If a practitioner fails to complete any delinquent charts within the time period specified, his/her Hospital admitting privileges shall be automatically suspended until all delinquent charts of his/her patients are completed;

(h) A practitioner whose privileges are suspended because of delinquent charts, may not admit patients under the name of another practitioner;

(i) Repeated automatic suspensions for failure to complete delinquent medical charts may result in monetary fines and referral to the MEC for possible corrective action. They may also be taken into account in determining whether to reappoint the applicant to the medical staff;

If a practitioner is suspended more than three times during any twelve (12) month period for medical records delinquency, and unless the Governing Board finds good cause to make an exception, the practitioner's Medical Staff membership and clinical privileges at the hospital (as applicable) shall automatically terminate, effective the same date as the suspension triggering termination. The practitioner shall have no right to a hearing (if applicable) or other due process, and no notice is required, as a prerequisite to the termination of the practitioner's Medical Staff membership and clinical privileges;

(j) Abiding by the lawful and ethical principles of the Indiana State Medical Association or the Indiana Osteopathic Association or the Indiana Dental Association, as such apply, and the respective national associations and by the standards of professional conduct and competent practice of medicine as set forth in 844 IAC 5-1 et. seq. and any amendments thereto or subsequently adopted standards;

(k) Aiding in any medical staff approved educational programs for medical students, interns, residents, physicians and allied health care providers;

(l) Working cooperatively with members, nurses, hospital administration and others so as not to affect patient care adversely;

(m) Performing patient care and related duties in a manner that is not disruptive to the delivery of quality medical care;

(n) Efficiently and effectively utilizing hospital resources;

(o) Taking appropriate arrangements for coverage for patients as determined by the Medical Staff;

(p) Refusing to engage in improper inducements for patient referral;

(q) Participating in continuing education programs as determined by the medical staff;

(r) Participating in such consultation panels as may be determined by the medical staff seeking consultation in cases when the diagnosis is obscure or when the best therapeutic measures are in doubt as required by 410 iac 15-1-7(2) (g);

(s) Notifying the Medical Executive Committee and the Hospital Administrator of any action(s), including any professional review actions(s), adversely affecting the physician by any health care entity, state licensure board, drug enforcement administration, Indiana Pharmacy Board, or court of law;

(t) Discharging such other staff obligations as may be lawfully established from time to

Time, by the medical staff;

(u) Participating in the hospital's OPPE and FPPE processes in order to ensure a high quality of patient care;

(v) Abiding by applicable hospital bylaws, rules, regulations and policies.

2.6 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 Hospital 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 or medical residency permit 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.

ARTICLE III
Categories of Membership

3.1 Categories

The categories of the medical staff shall include the following: Active, Courtesy, Consulting, Honorary, and Administrative. All of the above, except for Honorary and Administrative will be provisional for six (6) months. At each time of re-appointment, the member's staff category shall be determined.

3.2 Active

3.2-1 Qualifications

(a) Meet the general qualifications for membership set forth in section 2.2;

(b) Must live and practice close enough to Gibson General Hospital to provide continuous care to their patients. If an arrangement for one's hospitalized patients has not been made with another physician or hospitalist, for example, the physician will be called for the care of their own patient.

(c) Regularly care for patients in this hospital or are regularly involved in medical staff functions, as determined by the medical staff and approved by the board; and

3.2-2 Prerogatives

Except as otherwise provided, the prerogatives of an active medical staff member shall be to:

(a) Admit patients and/or exercise such clinical privileges as are granted pursuant to Article VI.

(b) Attend and vote on matters presented at general and special meetings of the medical staff and of the department and committees of which they are a member.

(c) Hold staff, committee, or department office and serve as a voting member of committees to which they are duly appointed or elected by the medical staff or a duly authorized representative thereof.

3.2-3 Transfer of Active Staff Member

After two (2) consecutive years in which a member of the active staff fails to provide care or consultation for patients in this hospital or be regularly involved in medical staff functions as determined by the medical staff and approved by the Board, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified or terminated.

3.3 Courtesy Medical Staff

3.3-1 Qualifications

The courtesy medical staff shall consist of members who:

(a) Meet the general qualifications set forth in subsections (a)-(b) of section 3.2-1;

(b) Do not regularly care for or are not regularly involved in the medical staff functions. A physician is eligible for courtesy staff appointment if they have twenty-five (25) or fewer patient admissions per year. If they have more than twenty-five (25) such patient admissions per year, they must apply for active membership; and

3.3-2 Prerogatives

Except as otherwise provided, the courtesy medical staff member shall be entitled to:

(a) Admit patients to the hospital within the limitations of section 3.4-1 (b) and/or exercise such clinical privileges as are granted pursuant to article VI.

(b) Attend in a non-voting capacity at meetings of the medical staff and the department

and committees of which they are a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Courtesy staff members shall not be eligible to hold office in the medical staff.

3.3-3 Limitation

Courtesy staff members who regularly admit patients or regularly care for patients at the Hospital shall, upon review of the executive committee, be obligated to seek appointment to the appropriate staff category.

3.4 Consulting Medical Staff

3.4-1 Qualifications

Any member of the medical staff in good standing may consult in their area of expertise; however, the consulting medical staff shall consist of physicians who:

(a) Are not otherwise members of the medical staff and meet the general qualifications set forth in section 2.2, except that this requirement shall not preclude an out-of-state physician from appointment to the consulting medical staff as may be permitted by law if that physician is otherwise deemed qualified by the medical staff, as approved by the board;

(b) Possesses adequate clinical and professional expertise; are willing and able to come to the hospital on schedule or

(c) Promptly respond when called to render clinical services within their area of competence;

(d) Are members of the active or associate medical staff of another hospital; and

3.4-2 Prerogatives

The consulting medical staff member shall be entitled to:

(a) Exercise such clinical privileges as are granted pursuant to article VI

(b) Attend meetings of the medical staff and the departments of which they are a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of the appointment. Consulting staff members shall not be eligible to hold office in the medical staff organization but may serve on committees though they are otherwise exempt from any other requirements of medical staff membership.

3.5 * Contract Staff

3.5-1 Clarification

(a) Contract Staff do not fall under a specific Contract Staff Category of Membership but may fall under any applicable Category of Membership and hold privileges in any applicable specialty they are qualified for and approved for.

The Contract Staff shall consist of members who:

(a) Meet the general qualifications for membership set forth in section 2.2;

(b) Possess adequate clinical and professional expertise in the specialty they are privileged in;

(c) Are under contract with the hospital to provide services; and

(d) Demonstrate adequate physical and mental health status and provide documentation thereof.

3.5-2 Prerogative

The Contract Staff shall be entitled to:

(a) Exercise such clinical privileges as are granted pursuant to article VI;

(b) Provide such care as shall be necessary in the setting they are privileged in within the hospital.

3.5-3 Limitations

(a) Members of the Contract Staff (excepting the Emergency Room Contract Staff):

(i). Shall have admitting privileges, if granted;

(ii). Clinical privileges and procedural rights afforded will be governed by their contract with the Hospital.

(b) Members of the Emergency Room Contract Staff:

(i). Shall be boarded in Emergency Medicine or, if boarded in another specialty, shall provide documentation of current cardiopulmonary resuscitation (“CPR”) certification, advanced cardiac life support (“ACLS”), advanced trauma life support (“ATLS”); and pediatric advanced life support (“PALS”).

Applicants to the Emergency Room Contract Staff who are not boarded in any specialty but are deemed to be board-eligible can be approved for

membership and privileges by the Credentialing Committee, Department of Medicine, and Medical Executive Committee for a period to be determined by these bodies. See also Section 2.3

(ii). Shall not have admitting privileges; if an emergency room patient requires admission to the Hospital for further treatment, the patient shall be admitted by a member of the Medical Staff who has admitting privileges.

3.6 Honorary Staff

3.6-1 Qualifications

The Honorary Staff shall consist of physicians who do not practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, who continue to exemplify high standard of professional and ethical conduct. This staff may also include those physicians who have retired and are in good standing.

3.6-2 Prerogatives

Honorary members are not eligible to admit patients to the Hospital or otherwise render medical care. They are not eligible to vote or hold office in this medical staff organization, but they may serve on committees. They may attend staff and department meetings including open committee meetings and educational programs.

3.7 Administrative Staff

3.7-1 Qualifications

The Administrative Staff shall consist of physicians who are retained solely to provide medical administrative functions and do not perform any active patient care duties.

3.7-2 Prerogatives

(a) Administrative Staff are not eligible to admit patients to the Hospital or otherwise render medical care.
(b) Administrative Staff are not eligible to hold office in this medical staff organization but may actively participate on committees and serve as voting members.
(c) They are not subject to OPPE for the purpose of credentialing or re-credentialing.

ARTICLE IV

Allied Health Care Providers

4.1 Conditions for Privileges of Allied Health Care Providers

4.1-1 Eligibility

Allied health care providers who are licensed and/or certified to practice in the State of Indiana, who maintain an active practice within a reasonable distance of the community served by the hospital, which shall be determined from time to time to be the service area of the hospital, who can document their education, training, experience and demonstrated competence, their adherence to the ethics of their professions, their good reputations, their ability to work with others in the provision of patient care, their ability and willingness to make efficient use of hospital facilities so as not to jeopardize the financial stability of the institution, and their good health, with sufficient adequacy to assure the medical staff and the Board of Directors that any patient treated by them in the hospital will be given an appropriate level of medical care, may qualify for privileges as allied health care provider shall be on a form developed by the medical staff and approved by the board and all information requested on such form shall be provided or accompanied with an explanation as to why such information cannot be provided. No such allied health care provider shall be entitled to exercise privileges as an allied health care provider in the Hospital merely by virtue of the fact that they are duly licensed or certified to practice his or her profession in this or any other state, or that they are a member of any professional organization or that they had in the past, or presently has such privileges at this or another hospital. No decisions on appointment as an allied health care provider or privileges will be influenced by an applicant's race, religion, sex or national origin.

4.1-2 Obligations

Application for and/or acceptance of privileges as an allied health care provider shall constitute the provider's agreement that they will strictly abide by the code of ethics which governs his or her professional organization and by all of the terms and provisions of the hospital and medical staff bylaws and rules and regulations as they now exist or hereafter shall be amended.

4.1-3 Hold Harmless Agreement

Application for and/or acceptance of privileges as allied health care provider shall constitute an agreement to authorize the members of the Medical Staff on behalf of the Board of Directors to inquire and to gather any and all information concerning the applicant and/or provider with regard to their qualifications to exercise privileges in the hospital, shall constitute an authorization to any and all persons and organizations to release such information to the Board of Directors, its agents and/or employees and shall constitute an agreement to release and hold harmless all persons and organizations, including the board of directors, its agents and employees and all others who participate in good faith in providing such information regarding the applicant.

4.1-4 Status of Allied Health Care Providers

Such persons shall be governed by these bylaws and shall be subject to the credentialing and peer review functions of the Medical staff, shall have no vote in Medical Staff elections or deliberations, are not required to attend Medical Staff meetings or to serve on any committees and are not entitled to any of the procedural rights afforded under articles vii and viii or elsewhere in these bylaws unless specifically stated otherwise. The Board of Directors, upon recommendation by the Medical Staff or any appropriate committee thereof may take whatever professional review action, including termination of privileges, it deems necessary, but is not required to comply with the procedural requirements of Articles VII and VIII. The Chief of Staff, in consultation with the applicable department chairman, may summarily suspend or restrict a provider's privileges as the circumstances may warrant, without recourse to the procedural requirements of Articles VII and VIII, except as otherwise stated herein. Such action by the Chief of Staff shall be referred to the Board for final action.

4.1-5 Credentialing of Allied Health Care Providers

The Credentials Committee shall review the application, credentials, references, and evidence of training and experience of all allied health care providers which are self-employed, employed by an agency or the employees of physicians and shall make recommendations to the medical staff who will in turn make recommendations to the Board of Directors on the specific privileges requested for delineation by the applicant. The credentialing of all allied health care providers which are employed by the hospital will be done administratively as part of the job application and job description process.

4.1-6 Medical Staff Sponsors

Since no allied health care provider may admit or co-admit patients to the Hospital and no allied health care provider can provide services to a patient in the Hospital except on the order of a physician, applications for privileges as an allied health care provider must contain the name of at least one medical staff member who has agreed to make use of the services of the applicant as an allied health care provider and who has agreed to supervise the quality of care of that allied health care provider within the hospital and agrees to be responsible for all aspects of the care and medical welfare of the patient, including care that is outside of the scope of the provider's license which may become necessary and care that is within the provider's license which is rendered by the provider. The exception to this requirement is the CRNA (Certified Registered Nurse Anesthetist) who may administer anesthesia under the direction of and in the immediate presence of a physician without that individual having agreed to be the CRNA's medical staff sponsor. A physician sponsor by signing such an application is not obligated to request the services of that allied health care provider thereafter but is obligated to supervise and review the quality of care being provided by that allied health care provider within the hospital. This includes the validation and countersigning by the physician sponsor or their designee, within 72 hours of any history and physical written by the allied health care provider. Any reapplication by a health care provider must be accompanied by a Sponsoring Physician Attestation written by the medical staff sponsor.

4.1-7 Privileges

A provider may only exercise those clinical privileges specifically granted by the Board, upon the recommendations of the medical staff, pursuant to any limitations, protocols or other requirements established by the applicable department, Medical Staff or the Board. At all times that the provider is exercising privileges in the hospital, they shall be subject to the supervision of the applicable department and the medical staff sponsor, with the exception of the CRNA as noted above. At all times the provider shall perform only those acts or procedures which are within the scope of their license as prescribed by law. All patients admitted by a physician member who will receive care rendered by a provider shall receive the same basic medical appraisal as patients ad mitted by a physician member, and a physician member shall determine the risk and effect of any proposed treatment or procedure on the general health status between a physician member and the provider, the physician member's opinion or the opinion of the appropriate department chairman shall prevail. Allied Health Care Providers that are granted clinical privileges at the Hospital will be subject to the Hospital's processes for FPPE and OPPE.

4.1-8 Malpractice Insurance

The allied health care provider or the physician-employer, where applicable, with the application for privileges, shall furnish proof of qualification of the allied health care provider under the provisions of the Indiana Medical Malpractice Act (i.c. 16-9.5 et. seq.) and of insurance at least equal to or exceeding the minimum limits provided for there under and shall agree to maintain qualification and insurance there under as a condition of eligibility for privileges there under.

ARTICLE V

Appointment and Re-appointment

5.1 General

Except as otherwise specified herein, no person (including persons engaged by the hospital in administratively responsible positions) shall exercise clinical privileges in the Hospital unless and until they apply for and receive appointment to the Medical Staff and are granted specific privileges or granted temporary privileges or granted privileges as an allied health care provider as set forth in these bylaws. By applying to the medical staff for appointment or re-appointment (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these bylaws and agrees that throughout any period of membership or any period in which they hold privileges, they will comply with the responsibilities of the Medical Staff membership as applicable, and with the bylaws and rules and regulations of the Medical Staff as they exist and as they may exist and be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with the bylaws.

5.2 Burden of Producing Information

In connection with all applications for appointment, re-appointment, advancement, transfer, or clinical privileges, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and/or staff category requested, resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychiatric examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee which may select the examining physician.

5.3 Appointment Authority

Appointments, denials and revocations of appointments to the Medical Staff and the granting of clinical privileges shall be made by the Board of Directors, but only after there has been a recommendation from the Medical Staff, including the Medical Director of the Facility for those physicians that admit to that facility.

5.4 Duration of Appointment and Re-appointment

Except as otherwise provided in these bylaws, initial appointments to the Medical Staff shall be for a period of three (3) years, except that the three-year appointment may be shortened so that the review process for re-appointments will coincide with the end of any medical staff year. Re-appointments shall be for a period of up to three (3) medical staff years.

5.5 Application of Initial Appointment

5.5-1 Application Form

An application form shall be developed by the Medical Executive Committee and approved by the Board of Trustees. The form shall require detailed information, which shall include, but not be limited to, information concerning:

(a) The applicant's qualifications, including, but not limited to professional training and experience, current licensure, current Indiana Controlled Registration as applicable, current DEA, as applicable, and continuing medical education information related to the clinical privileges to be exercised by the applicant;

(b) Appropriate references by persons familiar with the applicant's professional competence and ethical character. Peer recommendation includes written information regarding the practitioner's current:

- Medical/Clinical knowledge
- Technical and clinical skills
- Clinical judgment
- Interpersonal skills
- Communication skills
- Professionalism

(c) Requests for membership category, department, and clinical privileges;

(d) Past or pending professional disciplinary action, action against membership in any medical society, licensure limitations, malpractice suits or related matters in any jurisdiction;

(e) Physical and mental health status;

(f) Professional liability insurance and qualification under the Indiana Medical Malpractice Act pursuant to section 2.2-1 (c).

(g) Voluntary or involuntary resignations, dismissal, non-renewals, or privileges diminished, revoked, refused or other disciplinary actions taken at any other Hospital or health care entity;

(h) A current photograph and

(i) A valid copy of a picture ID issued by a state or federal agency (example, driver's license or passport)

(j) Records of training and experience in medical and/or surgical cases to include Procedure logs, also certificates of completion, where the applicant participated In their post graduate medical education program. This requirement may be Waived by a vote of the Medical Staff.

Each application for initial appointment to the medical staff shall be in writing and Signed by the applicant to the medical staff shall, be in writing and signed by the applicant. They may review these bylaws, the medical staff rules and regulation, The hospital corporate bylaws, and the other application policies relating to clinical practice in the Hospital, if any, which are maintained in the administration office.

5.5-2 Initial Appointment Procedure

Upon request, the medical staff office or Credentials Verification Organization (CVO) will provide to prospective applicants an application package that includes the following:

(a) A blank application form with a cover letter outlining requirements for completion

(b) A list of required supporting information

(c) A privilege request form(s)

(d) A detailed list of requirements for completion of the application

Effect of Application

The applicant must sign and date the application form. This signature will signify the applicant's agreement to all of the following:

a) Attestation to the accuracy and completeness of all information on the application or accompanying documents and agreement that any inaccuracy, omission, or misrepresentation – whether intentional or not – may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission, or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges may lapse effective immediately upon notification of the individual, without the right to a fair hearing or appeal.

b) Consent to appear for any requested interviews in regard to his or her application.

c) Authorization of hospital and medical staff representatives to consult with prior and current associates and others who may have information bearing on their professional competence, character, ability to perform the procedures, etc., for which privileges are requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested. This includes requesting information from previous professional liability carrier(s) that have insured the applicant.

   Consent for hospital and medical staff representatives' inspection of all records and documents that are material to an evaluation of their professional qualifications and competence to carry out the clinical privileges requested, of their physical and mental health status to the extent relevant to the capacity to fulfill requested privileges, and of their professional and ethical qualifications.

d) Applicant releases from any liability all persons and entities, including without limitation the Hospital, its Medical Staff, its Board of Trustees, personnel of peer review and other committees, and their agents, employees, and all others for acts performed and statements made in connection with evaluation of the application and their credentials and qualifications.
e) Applicant releases from any liability all individuals and organizations providing information, including otherwise privileged or confidential information, to the Hospital or the Medical Staff concerning their background, experience, competence, professional ethics, character, physical and mental health to the extent relevant to the capacity to fulfill requested privileges, emotional stability, utilization practice patterns, and other qualifications for staff appointment and clinical privileges.

f) Authorization of the Hospital medical staff and administrative representatives to release to other hospitals, medical associations, licensing boards, and other organizations concerned with this provider's performance and the quality and efficiency of this provider's patient care any information relevant to such matters that the Hospital may have concerning them and the release of the Hospital representative from liability for so doing. For the purposes of this provision, the term "Hospital representatives" includes the governing board, its directors and committees, the CEO or their designee, registered nurses and other employees of the Hospital, the medical staff organization and all Medical Staff appointees, clinical units, and committees that have responsibility for collecting and evaluating the applicant's credentials or acting upon their application, and any authorized representative of any of the foregoing.

g) The applicant has been oriented to the current Medical Staff bylaws, including its associated manuals and rules, regulations, policies, and procedures of the medical staff, and agrees to abide by their provisions. Such orientation will include at least one of the following: receiving an electronic copy of the bylaws and associated manuals, or review a hard copy, which is available in the Medical Staff office, of the expectations of medical staff members.

Procedure for Processing Applicants for Initial Staff Appointment:

a) A completed application includes, at a minimum:
    - A completed, signed, and dated application form
    - A completed request for privileges
    - Copies of all documents and information necessary to confirm that the applicant meets the criteria for membership and/or privileges
    - All applicable fees
    - All requested references

An application may be determined incomplete by the Medical Staff Executive Committee at the recommendation of the Credential Committee if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing the application. The Medical Staff Credentials/Executive Committee will follow up with the applicant in the event of an incomplete application.

b.) The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the medical staff office receives all required supporting documents verifying information on the application and providing sufficient

evidence, as required at the sole discretion of the Medical Staff Credentials/Executive Committee and that the applicant meets the requirements for medical staff membership and the privileges requested. If information is missing from the application – or if new, additional, or clarifying information is requested as determined by the Medical Staff Credentials /Executive Committee – a letter requesting such information will be sent to the applicant. If the requested information is not returned to the medical staff office within 45 days of the receipt of the request letter, an update would be given to the Medical Staff Credentials/Executive Committee for further actions. No consideration will be given to an application that remains materially incomplete.

c.) Upon receipt of a completed application as defined above, the applicant will be sent a communication by the Medical Staff Services office or CVO. Individuals seeking appointment and reappointment shall have the burden of producing any additional information deemed necessary by the Medical Staff Credentials/Executive Committee for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts.

d.) Any applicant not meeting the minimum objective requirements for membership to the medical staff, as outlined in Section 5.5 above, will have their application reviewed by the Medical Staff Credentials/Executive Committee, at which time they will make a decision to either process the application or deem it as an incomplete application.

e.) Upon receipt of a completed application, the medical staff office or CVO will verify its contents from acceptable sources and collect additional information as follows:

- Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments (if any) during the past 10 years
- Documentation of the applicant's past clinical work experience
- Licensure status in all current or past states where the applicant has held a license
- Information from the AMA or AOA Physician Profile, CMS/OIG list of excluded individuals, Fraud and Abuse Control Information System, or other such data banks, and including criminal background check
- Verification of the completion of professional training programs, including residency and fellowship programs
- Information from the National Practitioner Data Bank
- Other information about adverse credentialing and privileging decisions
- One or more peer recommendations from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, ethical character, and ability to work with others.
- Additional information as may be requested to ensure applicant meets the criteria for medical staff membership and/or requested privileges
- Recent photograph and valid copy of a picture ID of the applicant to verify identity, if not previously made available
- Information from a criminal background check

5.5-3 Credentials Committee Action

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

5.5-4 Medical Executive Committee Action

At its next regular meeting, after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Executive Committee shall consider the report and any other relevant information. The Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant. The Executive Committee shall forward to the Medical Staff recommendations as to the appointment, department affiliation, clinical privileges to be granted, and/or special conditions to be attached to the appointment. The Medical Staff shall forward to the administrator for prompt transmittal to the Board of Directors, recommendations as to the Medical Staff appointment or non-appointment, department affiliation, privileges to be granted and any special conditions to be attached to the appointment. The Executive committee or Medical Staff may also defer action on the application. The reasons for each recommendation shall be stated.

5.5-5 Effect of Medical Staff Action

(a) Favorable recommendation: when the recommendation of the Medical Staff is favorable to the applicant, it shall be promptly forwarded, together with the supporting documentation, to the Board of Directors.

(b) Adverse recommendations: when a final recommendation of the Medical Staff is adverse to the applicant, the Board of Directors and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to such procedural rights under Article VIII as are permitted the applicant elsewhere in these bylaws.

5.5-6 Action on the Application

The Board of Directors may accept or reject the recommendations of the Medical Staff or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral. The following procedures shall apply with respect to action on an application:

(a) If the Medical Staff Issues a favorable Recommendation and

(1) The Board of Directors concurs in that recommendation; the decision of the board shall be deemed final action.

(2) If the decision of the Board of directors is unfavorable, the applicant may request a hearing by a hearing committee appointed by the Board and

the other appeal mechanisms pursuant to Article VIII of these bylaws, and in accordance with the prescribed sequence of steps and chronologies mandated by Article VIII, except that this does not apply to allied health care providers where the decision of the Board is final with out recourse to hearing and appeal.

(b) In the event the recommendation of the Medical Staff is unfavorable to the applicant, the procedural rights set forth in Article VIII shall apply (except that such shall not apply to allied health care providers as stated in section 5.5-7(a) (2); and

(1) If no hearing committee hearing is requested by the applicant, the recommendation of the Medical Staff shall be referred to the Board of Directors for final action.

(2) If a hearing is requested and the decision of the hearing committee is unfavorable to the applicant, and if the Board of Directors concurs in the unfavorable recommendation following an appeal pursuant to Article VIII, the decision of the Board shall be deemed final action. If the Board of Directors does not concur with the unfavorable recommendation of the hearing committee following an appeal, and the Board's decision is unfavorable to the applicant, the decision of the Board shall be deemed final action.

(3) If a hearing is requested and the decision of the hearing committee is favorable to the applicant, but the Board of Directors concurs in the unfavorable recommendation of the Medical Staff following an appeal pursuant to Article VIII, the decision of the Board shall be deemed final action. If the Board concurs with the favorable decision of the hearing committee following an appeal, the decision of the Board shall be deemed final action.

5.5-7 Notice of Final Decision

(a) Notice of the final decision shall be given to the Chief of Staff, the Medical Executive and the Credentials Committee, the chairman of each department concerned, the applicant and the Administrator.

(b) A decision and notice to appoint or re-appoint shall include, if applicable; (1) the staff category to which the applicant is appointed; (2) the department to which he is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

5.5-8 Re-application after Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment and/or privileges shall not be eligible to reapply to the Medical Staff or to reapply for privileges for a period of one (1) year. Any such re-application shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

5.5-9 Timely Processing of Applications

Applications for staff appointments shall be considered in a timely manner by all persons and committees required by these bylaws to act thereon. Special or unusual circumstances may constitute good cause and warrant exceptions. Final action is generally to take place within six (6) months.

5.6 Procedure for Reappointment

At least five (5) months prior to the expiration date of the current staff member's appointment, a reapplication form will be sent by the medical staff office or CVO. If an application for reappointment is not received at least 45 days prior to the expiration date, a written notice shall be sent to the applicant advising that an application has not been received and reminding them of their expiration date and a date necessary to receive the application by to avoid interruption of membership and clinical privileges.

1) The reapplication shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to:
   a) A Summary of Clinical Activity/Procedure Log if you, as the provider, have not performed any surgeries or procedures at GGH during your previous appointment. This procedure log will need to come from an outside facility.
   b) Performance and conduct in this hospital and other hospitals (where available) in which a practitioner has provided substantial clinical care since the last appointment or reappointment, including, without limitation, patterns of care as demonstrated in findings of quality assessment/performance improvement activities, their clinical judgment and skills in treatment of patients, and their behavior and cooperation with peers, hospital personnel and patients.
   c) Attestation of 50 hours of continuing medical education activities within the last two years.
   d) Service on medical staff, department, and hospital committees
   e) Timely and accurate completion of medical records
   f) Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and medical staff.
   g) Explanation of any gaps in employment or practice since the previous appointment or reappointment.
   h) One peer recommendation which includes written information regarding the practitioner's current:
      - Medical/Clinical knowledge
      - Technical and clinical skills
      - Clinical judgment
      - Interpersonal skills
      - Communications skills
      - Professionalism

i) Evidence of professional liability coverage and malpractice history for the past two years from a primary source verified by the malpractice carrier(s).
j) Utilization of the Hospital's programs and healthcare services provided
k) Query to the National Practitioner Data Bank

2) Criteria for reappointment:
It is the policy of the Hospital to approve for reappointment only those individuals who meet the criteria for reappointment as identified in Section 5.5-2 and who have been determined by the MEC to be providers of effective care that is consistent with the Hospital standards of ongoing quality as determined by the MEC and appropriate medical staff department.

5.6-2 Effect of Application

The effect of the application for re-appointment or modification of staff status or privileges is the same as that set forth in section 5.5-2.

5.6-3 Standards and Procedures for Review

When a staff member submits the first application for re-appointment, and every two years thereafter, except as provided under section 5.4 or when the member submits an application for an increase of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in this Article V.

5.6-4 Failure to File Re-appointment Application

Failure without good cause to file a completed application for re-appointment in a timely manner shall result in the automatic suspension of the member's admitting privileges and the expiration of other clinical privileges and prerogatives at the end of the current staff appointment, unless otherwise extended by the Executive Committee with the approval of the Board of Directors. If the member fails to submit a complete application for re-appointment within thirty (30) days past the date it was due, member shall be deemed to have resigned membership in the medical staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VIII shall not apply except for the sole purpose of determining whether the failure to timely file a completed application for re-appointment was for good cause.

5.7 Leave of Absence

5.7-1 Leave Status

At the recommendation of the Medical Staff and the approval of the Board, a Medical Staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Executive Committee, stating the approximate period of leave desired and the purpose thereof. During the period of leave, the member shall not exercise clinical privileges at the hospital and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff.

5.7-2 Termination of Leave

At least thirty (30) days prior to termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Executive Committee. The staff member shall submit a summary of relevant activities during the leave, if the Executive Committee so requests. The Medical Staff shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the procedures provided in sections 5.1 through 5.5-10 shall be followed.

5.7-3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VIII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise for good cause. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE VI

Clinical Privileges

6.1 Exercise of Privileges

Except as otherwise provided in these bylaws, a member or allied health care provider providing clinical services at this Hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be Hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the rules and regulations of the clinical department and authority of the department chairman and Medical Staff.

6.2 Delineation of Privileges for Medical Staff Members

6.2-1 Requests

Each application for appointment and re-appointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for the modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

6.2-2 Basis for Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the Medical Staff and the Board deem appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

6.2-3 Telemedicine Clinical Privileges

Applicants based at distant-site hospitals or entities who are requesting telemedicine clinical privileges at the Hospital may apply for such clinical privileges and appointment to the Medical Staff provided each applicant meets the basic qualification for appointment set forth in Section 2.2 and by submission of the same application or application with equivalent content as specified in Section 5.5.-1. All determinations regarding

equivalent content will be made by the MEC. Applicants seeking appointment to the Medical Staff and who are seeking telemedicine clinical privileges may, but need not, be processed pursuant to the complete appointment procedure described in Article V. Alternatively, in the case of applicants who intend to provide telemedicine services under a written agreement between the Hospital and a distant–site hospital or entity, in lieu of the procedures set forth in Article V, the MEC may make recommendations directly to the Board regarding such applicants in reliance upon the privileging decision of the distant-site hospital or entity and in compliance with applicable regulatory body standards and federal and/or state law.

6.3 Focused Professional Practice Evaluation/Initial Practice Evaluation

All initial appointees to the Medical Staff, and all members granted new or additional clinical privileges, shall be subject to a period of focused professional practice evaluation ("FPPE") pursuant to the Hospital's FPPE Policy. During the period of FPPE, and unless a different or additional criteria/requirements are identified, the relevant department chairperson (or designee) shall observe/evaluate the appointee's performance in an appropriate number of cases, as determined by the department chairperson, in conjunction with the MEC, in order to determine the appointee's suitability to continue to exercise membership and clinical privileges (as applicable). Following such period of observation/evaluation, the department chairperson (or designee) shall complete a report, which describes: the types and number of cases observed, an evaluation of the appointee's performance, and includes a recommendation regarding whether or not the appointee should be permitted to exercise the clinical privileges sought without further supervision. The report shall also address the appointee's conduct and compliance with the Medical Staff Bylaws, Rules, Regulations and all pertinent policies.

6.4 Ongoing Professional Practice Evaluation

All practitioners with an independent scope of practice who are granted clinical privileges at the Hospital shall be subject to ongoing professional practice evaluation ("OPPE") as set forth in the Hospital's OPPE Policy. OPPE is integrated into the Hospital's credentialing and performance improvement activities in order further the quality of patient care.

All practitioners subject to OPPE are required to maintain a sufficient degree of volume/activity at the Hospital so as to permit meaningful evaluation of their performance through OPPE. In the event a department chairperson, MEC, Board, or other applicable peer review committee determines that a practitioner has not demonstrated sufficient volume/activity at the Hospital to permit meaningful OPPE, the practitioner may be requested to promptly provide, or cause to be provided, (authenticated) information/data from the practitioner's primary practice location(s). A practitioner's failure to timely comply with such a request, or a practitioner's failure to demonstrate any volume/clinical activity at the Hospital, may result in administrative action, including the automatic/administrative resignation of that practitioner's Medical Staff Membership and/or Clinical Privileges at the Hospital (as applicable) as more fully described in Article VII of these Bylaws.

6.5 Credentialing and Peer Review Standards

These standards shall be carried out in a fashion as described in these by-laws and as

described in the medical staff section under credentialing and peer review standards (See Peer Review Policy).

6.6 Temporary Clinical Privileges

6.6-1 Circumstances

(a) Temporary privileges may be granted by the CEO acting on behalf of the board, upon written concurrence of the chairperson or designee of the department in which the privileges will be exercised, and by the Chief of the medical staff or designee provided that there is verification of the applicant's current licensure and current competence.

Temporary privileges may be granted in only two circumstances:

1.) To fulfill an important patient care need;
2.) When an initial applicant with a completed, clean application is awaiting review and approval of the MEC and the Board.

(b) In either case, the CEO or designee may not grant temporary privileges unless the following information has been verified through mechanisms acceptable to the hospital.

1.) Current license to practice within the state
2.) Relevant training or experience
3.) Current competence
4.) Ability to perform privileges requested
5.) Malpractice insurance
6.) Freedom from prior disciplinary actions by any healthcare-related organization
7.) Freedom from prior criminal conviction
8.) Absence of a pattern of malpractice suits raising concern about competence
9.) Freedom from current sanction by a branch of the federal or state government
10) Data Bank Query

Under no circumstances will the CEO or designee grant temporary privileges for greater than 60 days without a written record of the pressing community or patient care need to be met by such action. A single 60-day extension of temporary privileges will be permitted. Under no circumstances will any practitioner provide service under temporary privileges for greater than 120 days.

Temporary privileges will not be permitted due to an incomplete application or failure of the institution to gather and verify all necessary performance data and information. Temporary privileges will not be granted until the applicant has agreed in writing to abide by the institution's medical staff bylaws, policies, rules, and regulations.

All grants of temporary privilege will automatically expire at the end of the time period for which they were granted. The practitioner shall be informed at least two weeks in advance and advised to make other arrangements for their patients currently in the hospital or in need of hospitalization.

6.6-2 General Conditions

Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded by the investigation,
corrective action, hearing and appeal plan procedures outlined in the medical staff bylaws if their request for temporary privileges is refused. However, they will be afforded these procedural rights if all or any part of their temporary privileges are terminated or suspended based on a determination of clinical incompetence or unprofessional conduct.

6.6-3 Procedure

Requests for temporary privileges will be in writing and reviewed to determine whether either of the two circumstances described above is present. If one is found to be present, a note or record will be made reflecting the circumstances warranting a consideration of the request. Immediately upon making a positive finding, the institution will conduct the following background checks using the most accurate and timely mechanism available:

1.) National Practitioner Data Bank
2.) Licensure (state-sponsored web site)
3.) American Medical Association AMA or American Osteopathic Association AOA Masterfile
4.) Office of Inspector General cumulative sanctions report
5.) American Board of Medical Specialties or AOA verification of board status (if needed)
6.) Telephone or written references from at least two individuals who have first-hand knowledge of the applicant's clinical abilities (at least one of whom must have been identified by the institution and not the applicant)
7.) Telephone or written reference confirmation of past practice (when the applicant has a very extensive history of past practices, the institution will ask about most recent practices)
8.) Criminal background check

At any time, temporary privileges may be terminated by the Medical Executive Committee or by the Chief of Staff with the concurrence of the appropriate department chairman or their designees, subject to prompt review by the Executive Committee. In such matters the Chief of Staff and the appropriate department chairman, or his designees, shall be deemed to be acting in the capacity of a peer review committee under I.C. 34-4-12.6 ET.SEQ and on behalf of the Board of Trustees. In such cases, the appropriate chairman, or, in the chairman's absence, the chairman of the executive committee, shall assign a member of the medical staff to assume responsibility for the care of such physician's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

6.7 Emergency Privileges

(a) In the case of an emergency, any member of the medical staff, to the degree permitted by their license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the patient's attending physician or, if appropriate, the department chairman concerning the need for emergency care and assistance by members of the medical staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the patient's attending physician or, if appropriate, the department chairman with respect to further care of the patient at the hospital.

(b) In the event of an emergency, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the medical staff when it becomes reasonably available.

6.8 Disaster Privileges

Licensed Independent Practitioners (LIP's), who do not possess medical/allied health staff privileges at Gibson General Hospital and volunteer practitioners who are required by law to have a license, certification, or registration may be granted emergency privileges during a "disaster". Emergency privileges will be granted only when the following two conditions are present: the Emergency Operation Plan (EOP) has been activated, and the organization is unable to meet the immediate patient needs. (See "Protocol for Credentialing Volunteer Practitioners in the Event of Disaster" policy).

6.9 Modification of Clinical Privileges or Department Assignment

On its own, upon recommendation of the credentials committee, or pursuant to a request under section 5.6-1(b), the Medical Executive Committee may recommend a change in the clinical privileges or department assignment(s) of a member. The Executive Committee may also recommend that the granting of additional privileges to a current medical staff member be made subject to monitoring in accordance with procedures similar to those outlined in section 6.3.

6.10 Lapse of Application

If a medical staff member requesting a modification of clinical privileges or department assignment fails to timely furnish the information necessary to evaluate the request within 90 days, the application shall automatically lapse, unless granted an extension by the Medical Executive Committee or the Board for good cause, and the applicant shall not be entitled to a hearing as set forth in Article VIII.

ARTICLE VII

Professional Review Action

7.1 Professional Review Action

7.1-1 Criteria for Initiation

Any person may provide information to the medical staff about the conduct, performance, or competence of its members or a provider. When reliable information indicates a member, or a provider may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the hospital; (2) unethical; (3) contrary to the medical staff or hospital bylaws or rules and regulations; or (4) below applicable professional standards, a request for an investigation or action against such member may be initiated by the Chief of Staff, a department chairman, the Medical Executive Committee, the Medical Staff or the Board of Directors.

7.1-2 Initiation

A request for an investigation must be in writing, and must be submitted to both the Medical Executive Committee and hospital administrator and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate recording of the reasons.

7.1-3 Investigation

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken, and it shall be completed with 30 days. Where a request for investigation follows completion of FPPE, the MEC (or any other committee to which it assigns an investigation) may adopt some or all of the investigation completed through FPPE as its own investigation if the MEC (or appointed committee) determines that such investigation was reliably performed, and efficiency is best served by not repeating that same investigation. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate medical staff department or standing or ad hoc committee of the medical staff. If the investigation is delegated to a committee other than the Medical Executive Committee, such committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate professional review action. The member shall be notified that an investigation is being conducted. In addition, the member shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with the persons involved; however, such investigations shall not constitute a “hearing” as that term is used in Article VIII nor shall the procedural rules with respect to hearings or appeals

apply. Despite the status of any investigation, at all times the Medical Executive Committee and the Board shall retain authority and discretion to take whatever action may be warranted by the circumstances.

7.1-4 Executive Committee Action

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action which may include, without limitation, the following and shall notify the Hospital Board of such action:

(a) Determining no corrective action be taken; and, if the Executive Committee determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the member's file.

(b) Deferring action for a reasonable time where circumstances warrant;

(c) Issuing letters of admonition, censure, reprimand or warning, although nothing herein shall be deemed to preclude department heads from issuing informational written or oral warnings outside of the mechanism for professional review action. Such letters of admonition, censure, reprimand or warning shall be considered educational and minor in nature rather than professional review action affecting privileges, shall not be reported to the Medical Licensing Board under the state or federal law and shall not give rise to the procedural rights set forth in Article VIII. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;

(d) Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

(e) Recommending reduction, modification, suspension or revocation of clinical privileges;

(f) Recommending reductions of membership status or limitations of any prerogative directly related to the member's delivery of patient care;

(g) Recommending suspension, revocation or probation of medical staff membership; or

(h) Taking other actions deemed appropriate under the circumstances.

7.1-5 Subsequent Action

a) If professional review action as set forth in section 8.2 (a) - (k) is recommended by the medical staff, that recommendation shall be transmitted to the Board of Directors.

(b) The recommendations of the medical staff shall be forwarded to the Board and, with the Board's approval, shall become final action unless the member requests

a hearing, in which case the final decision shall be determined as set forth in Article VIII.

7.2 Summary Restrictions or Suspension

7.2-1 Criteria for Initiation

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of a patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient, prospective impairment of the life, health, or safety of any patient, prospective patient, or other person, the Chief of the Medical Staff, in consultation with the head of the appropriate department or his designee, the Medical Executive Committee or the Board of Directors or other designated committee may summarily restrict or suspend the clinical privileges of such member. In such matters, the Chief of Staff and the appropriate department chairman, or their designees, shall be deemed to be acting in the capacity of a peer review committee under I.C. 34-4-12.6 et. seq. and on behalf of the Board of Directors. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the committee responsible shall promptly give written notice to the member, the Board of Directors, the Medical Executive Committee and the administrator. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chairman or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

7.2-2 Medical Executive Committee

Within ten (10) calendar days after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review, investigate and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article VIII, nor shall any procedural rules apply to the member's failure without good cause to attend any such Medical Executive Committee meeting upon request shall constitute a waiver of such right to attend. The Medical Executive Committee must make a recommendation to modify, continue or terminate the summary restrictions or suspension within fourteen (14) days after the restriction was imposed, but in any event, it shall furnish the member, the Board of Directors, the administrator and the medical staff with notice of its recommendation.

7.2-3 Procedural Rights

Unless the Medical Executive Committee promptly terminates the summary restrictions or suspension within the fourteen (14) day period specified above, the member shall be entitled to other procedural rights afforded by Article VIII.

7.3 Administrative Actions

The following provisions for administrative action shall apply to all members and other clinically privileged practitioners at the Hospital (collectively referred to in this section as "practitioners"):

7.3-1 License to Practice

Each practitioner shall at all times maintain a current and valid license to practice his/her profession in the State of Indiana. In the event a practitioner's license is revoked, suspended, not renewed, restricted or limited or if the practitioner's license is placed on probation, he/she shall immediately notify the Medical Staff President and Hospital Administrator.

(a) Revocation of License. Whenever a practitioner's license to practice in Indiana is revoked, the practitioner's Medical Staff membership and clinical privileges at the Hospital shall (as applicable) automatically terminate. Such termination shall be effective the same date as the revocation of the license. The practitioner shall have no right to a hearing (if applicable) or other due process rights, and no notice to the practitioner is required, as a prerequisite to termination.

(b) Suspension or Nonrenewal of License. Whenever a practitioner's license to practice in Indiana is suspended or not renewed, the practitioner's Medical Staff membership and clinical privileges at the Hospital (as applicable) shall be automatically suspended. The suspension shall be effective the same date as the suspension or non-renewal of the license (as applicable). The practitioner shall remain suspended until the practitioner provides reliable evidence to the MEC and CEO that the underlying suspension of the license is lifted or that the license is appropriately renewed (as applicable). In the event the practitioner's license remains suspended or not renewed for a period greater than sixty (60) days, and unless the Governing Board determines that there is good cause to delay automatic termination, the practitioner's membership and clinical privileges at the Hospital (as applicable) shall automatically terminate effective sixty-one (61) days after the suspension or non-renewal of the license. The practitioner shall have no right to a hearing (if applicable) or other due process rights, and no notice to the practitioner is required, as a prerequisite to either suspension or termination of the practitioner's Medical Staff membership and clinical privileges (as applicable). In the event a licensure suspension is lifted prior to the expiration of sixty (60) days and a practitioner's corresponding medical staff suspension is also lifted, nothing herein precludes the MEC (or any other individual) from initiating a professional review action (or taking other applicable action), as set forth in Section 7.1, above, resulting from circumstances related to the licensure suspension or nonrenewal.

(c) Restriction or Limitation of License. Whenever a practitioner's license to practice in Indiana is restricted or limited, the practitioner's Medical Staff membership and clinical privileges (as applicable) shall be automatically and immediately restricted/limited in accordance with the underlying licensure restriction or limitation (as applicable). The restriction/limitation of Medical Staff membership and clinical privileges (as applicable) shall be effective the same date as the restriction/limitation of the license (as applicable). The practitioner shall remain restricted/limited until the practitioner provides reliable evidence to the MEC and CEO that the underlying restriction/limitation of the license is lifted. In the event the practitioner's license remains limited/restricted for a period greater than sixty (60) days, and unless the Governing Board determines that there is good cause to delay automatic termination, the practitioner's membership and clinical privileges at the Hospital (as applicable) shall automatically terminate effective sixty-one (61) days after the suspension or non-renewal of the license. The practitioner shall have no right to a hearing (if applicable) or other due process rights, and no notice to the practitioner is required, as a prerequisite to either the restriction/limitation or termination of the practitioner's Medical Staff membership and clinical privileges. In the event a licensure restriction/limitation is lifted prior to the expiration of sixty (60) days and a practitioner's corresponding medical staff restriction/limitation is also lifted, nothing herein precludes the MEC (or any other individual) from initiating a professional review action (or taking other applicable action), as set forth in Section 7.1, above, resulting from circumstances related to the licensure restriction/limitation.

(d) Probation of License. Whenever a practitioner's license to practice in Indiana is placed on probation, the matter is automatically deemed a request for a professional action and should be promptly forwarded to the MEC for pursuant to Section 7.1, above.

(e) License to Practice in a State other than Indiana. Whenever a practitioner's license to practice in any state other than Indiana is revoked, suspended, restricted, limited, or placed on probation, the matter is automatically deemed a request for a professional action and should be promptly forwarded to the MEC for pursuant to Section 7.1, above.

7.3-2 DEA Registration/Indiana Controlled Substance Registration

Unless otherwise exempt pursuant to the Medical Staff Bylaws, Rules, Regulations or policies, or unless otherwise unnecessary for a practitioner to fully exercise the clinical privileges that have been granted to them, practitioners are required to maintain a current and valid Federal Drug Enforcement Administration ("DEA") registration (with appropriate registration in Indiana) and Indiana controlled substance registration. In the event a practitioner's Federal or Indiana registration is revoked, suspended, non-renewed, restricted or limited, or if the practitioner's registration is placed on probation, he/she shall immediately notify the Chief of Staff and CEO.

(a) Revocation, Suspension or Non-renewal of Registration. Whenever a practitioner's Federal DEA or Indiana controlled substances registration is

revoked, suspended or not renewed ("non-renewal" also refers to and includes a failure to appropriately obtain, register or maintain registration), the practitioner's Medical Staff membership and clinical privileges at the Hospital (as applicable) shall be automatically suspended. The suspension shall be effective the same date that the Federal DEA or Indiana controlled substances registration is revoked, suspended, not renewed, or otherwise not valid (as applicable). The practitioner shall remain suspended until the practitioner provides reliable evidence to the MEC and CEO that the underlying revocation or suspension is lifted or that the registration is appropriately renewed/obtained (as applicable). In the event the practitioner's Federal DEA or Indiana controlled substances registration is revoked, suspended or not renewed/obtained for a period greater than sixty (60) days, and unless the Governing Board determines that there is good cause to delay automatic termination, the practitioner's membership and clinical privileges at the Hospital (as applicable) shall automatically terminate effective sixty-one (61) days after the effective date of the suspension. The practitioner shall have no right to a hearing (if applicable) or other due process, and no notice to the practitioner is required, as a prerequisite to either suspension or termination of the practitioner's Medical Staff membership and clinical privileges (as applicable). In the event a revocation, suspension or non-renewal is resolved prior to the expiration of sixty (60) days and a practitioner's corresponding medical staff suspension is also lifted, nothing herein precludes the MEC (or any other individual) from initiating a professional action (or taking other applicable action), pursuant to Section 7.1, above, resulting from circumstances related to the revocation, suspension or nonrenewal of the Federal DEA or Indiana controlled substances registration.

(b) Restriction or Limitation of Registration. Whenever a practitioner's Federal DEA or Indiana controlled substances registration is restricted or limited, the practitioner's Medical Staff membership and clinical privileges (as applicable) shall be automatically and immediately restricted/limited in accordance with the underlying restriction or limitation or registration (as applicable). The restriction/limitation shall be effective the same date that the Federal DEA or Indiana controlled substances registration restricted/limited. The practitioner shall remain restricted/limited until the practitioner provides reliable evidence to the MEC and CEO that the underlying restriction/limitation is lifted. In the event the practitioner's Federal DEA or Indiana controlled substances registration is restricted/limited for a period greater than sixty (60) days, and unless the Governing Board determines that there is good cause to delay automatic termination, the practitioner's membership and clinical privileges at the Hospital (as applicable) shall automatically terminate effective sixty-one (61) days after the restriction/limitation. The practitioner shall have no right to a hearing (if applicable) or other due process, and no notice to the practitioner is required, as a prerequisite to restriction/limitation or termination of the practitioner's Medical Staff membership and clinical privileges (as applicable). In the event a restriction/limitation is resolved prior to the expiration of sixty (60) days and a practitioner's corresponding medical staff restriction/limitation is also lifted, nothing herein precludes the MEC (or any other individual) from initiating a professional action (or taking other

applicable action), pursuant to Section 7.1, above, resulting from circumstances related to the restriction/limitation of the Federal DEA or Indiana controlled substances registration.

(c) Probation of Registration. Whenever a practitioner's Federal DEA or Indiana controlled substances registration is placed on probation, the matter is automatically deemed a request for a professional action and should be promptly forwarded to the MEC for pursuant to Section 7.1, above.

(d) Controlled Substances Registration in a State other than Indiana. Whenever a practitioner's Federal DEA or Indiana controlled substances registration in any state other than Indiana is revoked, suspended, restricted, limited or placed on probation, the matter is automatically deemed a request for a professional action and should be promptly forwarded to the MEC for pursuant to Section 7.1, above.

7.3-3 Medicare/Medicaid Sanctions

Practitioners shall at all times remain eligible to participate in the Medicare and Medicaid programs. In the event that a practitioner's Medicare and/or Medicaid participation is revoked, suspended, revoked, limited or placed on probation or if he/she receives notice of any investigation or possible disciplinary action, the practitioner shall immediately notify the Medical Staff President and Hospital Administrator.

(a) Revocation, Suspension, Restriction or Limitation of Participation. Whenever a practitioner's eligibility to participate in the Medicare and/or Medicaid programs is revoked, suspended, restricted or limited, the practitioner's Medical Staff membership and clinical privileges at the Hospital (as applicable) shall be automatically suspended. The suspension shall be effective the same date that the practitioner's eligibility to participate in the Medicare and/or Medicaid programs is revoked, suspended, restricted or limited. The practitioner shall remain suspended until the practitioner provides reliable evidence to the MEC and CEO that the underlying revocation, suspension, restriction or limitation has been lifted. In the event the practitioner's eligibility to participate in the Medicare and/or Medicaid programs is revoked, suspended, restricted or limited for a period greater than sixty (60) days, and unless the Governing Board determines that there is good cause to delay automatic termination, the practitioner's membership and clinical privileges at the Hospital (as applicable) shall automatically terminate effective sixty-one (61) days after the revocation, suspension, restriction or limitation. The practitioner shall have no right to a hearing (if applicable) or other due process, and no notice to the practitioner is required, as a prerequisite to either suspension or termination of the practitioner's Medical Staff membership and clinical privileges (as applicable). In the event a revocation, suspension, restriction or limitation is resolved prior to the expiration of sixty (60) days and a practitioner's corresponding medical staff suspension is also lifted, nothing herein precludes the MEC (or any other individual) from initiating a professional action (or taking other applicable action), pursuant to Section 7.1, above, resulting from circumstances related to the revocation, suspension,

restriction or limitation of the practitioner's eligibility to participate in the Medicare and/or Medicaid programs.

(b) Probation of Participation. Whenever a practitioner's eligibility to participate in the Medicare and/or Medicaid programs is placed on probation, the matter is automatically deemed a request for a professional action and should be promptly forwarded to the MEC for pursuant to Section 7.1, above.

7.3-4 Criminal Arrest, Charge or Conviction

Practitioners are required to conduct themselves in a manner that is befitting of their profession. This requirement includes the expectation that practitioners will not engage in criminal activity. In the event a practitioner is arrested, charged with, or convicted of any crime, he/she shall immediately notify the Chief of Staff and CEO.

(a) Suspension. In the event a practitioner has been arrested or formally charged with:

i. a felony level crime;

ii. a crime against another person or persons, such as murder, rape, assault or other similar crime;

iii. a crime that placed a patient at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct;

iv. a financial crime, such as extortion, embezzlement, income tax evasion, insurance fraud or other similar crime; or

v. any crime that would result in mandatory exclusion from the Medicare or Medicaid programs;

the Governing Board, following recommendation by the MEC, may elect to administratively suspend the practitioner's Medical Staff membership and clinical privileges at the Hospital (as applicable) pending resolution of the underlying arrest and/or charge. The practitioner shall have no right to a hearing (if applicable) or other due process, and no notice to the practitioner is required, as a prerequisite to suspending the practitioner's Medical Staff membership and clinical privileges (as applicable). In the event a suspension is ultimately lifted, the practitioner may in the discretion of the pertinent Department Chairperson and MEC, be required to comply with a plan for FPPE. Additionally, and irrespective of whether the practitioner is suspended, nothing herein precludes the MEC (or any other individual) from initiating a professional action (or taking other applicable action), pursuant to Section 7.1, above, resulting from circumstances related to the arrest or charge, even where such arrest or charge does not result in conviction.

(b) Termination. In the event a practitioner is convicted of a crime identified in Section 3.4(a), above, the practitioner's Medical Staff membership and clinical privileges at the Hospital (as applicable) shall immediately terminate. The practitioner shall have no right to a hearing (if applicable) or other due process, and no notice to the practitioner is required, as a prerequisite to termination of the practitioner's Medical Staff membership and clinical privileges (as applicable).

7.3-5 Medical Record Completion

Practitioners shall at all times comply with the Hospital's prevailing policy on medical record completion, which shall set forth the review and notification process regarding patient chart deficiency and delinquency. To the extent the provisions set forth in this Section conflict with the Hospital's medical record completion policy, this Section shall govern. A practitioner whose clinical privileges are suspended because of delinquent charts must arrange in a timely manner for the appropriate transfer of care of his/her admitted patients to another appropriately privileged practitioner. A practitioner may request a written waiver of these requirements in advance of extended planned vacations or professional absences, provided any such waiver will not result in medical records in question being noncompliant with laws and accreditation standards applicable to Hospital.

(a) Suspension. The Medical Staff President will give the affected practitioner and the MEC written notice that practitioner's admitting privileges have been automatically suspended because of his or her delinquent records. The practitioner shall have no right to a hearing (if applicable) or other due process as a prerequisite to the suspension of the practitioner's Medical Staff membership and clinical privileges.

(b) Termination. If a practitioner is suspended more than three times during any twelve (12) month period for medical record delinquency, and unless the Governing Board finds good cause to make an exception, the practitioner's Medical Staff membership and clinical privileges at the Hospital (as applicable) shall automatically terminate, effective the same date as the suspension triggering termination. The practitioner shall have no right to a hearing (if applicable) or other due process, and no notice is required, as a prerequisite to the termination of the practitioner's Medical Staff membership and clinical privileges.

(c) Voluntary Resignation. A practitioner who remains suspended by the terms of this Section and/or the applicable Medical Staff Policy on medical record completion for more than sixty (60) days shall be deemed to have voluntarily resigned his or her Medical Staff membership and clinical privileges (as applicable), without right of hearing, appeal, or other due process (if applicable). In such event, the practitioner may reapply for Medical Staff membership or clinical privileges as a new applicant, pursuant to the procedures set forth in the Medical Staff Bylaws.

7.3-6 Failure to Maintain Professional Liability Insurance

Practitioners shall at all times maintain professional liability insurance in the form, amounts and limits established by the Governing Board (including any requisite participation as a "qualified healthcare provider" within the meaning and intent of Indiana's Medical Malpractice Act). In the event that a practitioner fails to maintain the required insurance and/or the limits of coverage are reduced below the requisite amounts, the practitioner shall immediately notify the Chief of Staff and CEO.

(a) Suspension. Whenever a practitioner fails to maintain professional liability insurance in the form, amounts and limits required by the Governing Board, the practitioner's Medical Staff membership and clinical privileges at the Hospital (as applicable) shall be automatically suspended. The practitioner shall have no right to a hearing (if applicable) or other due process, and no notice is required, as a prerequisite to the termination of the practitioner's Medical Staff membership and clinical privileges (as applicable). The practitioner shall remain suspended until the practitioner provides reliable evidence to the MEC and CEO that the practitioner has obtained professional liability insurance in the form, amounts and limits required by the Governing Board.

(b) Voluntary Resignation. In the event the practitioner remains suspended pursuant to this Section for a period greater than sixty (60) days, and unless the Governing Board determines that there is good cause to make an exception, the practitioner shall be deemed to have voluntarily resigned his or her Medical Staff membership and clinical privileges (as applicable), without right of hearing, appeal, or other due process (if applicable). In such event, the practitioner may reapply for Medical Staff membership or clinical privileges (as applicable) as a new applicant, pursuant to the procedures set forth in the Medical Staff Bylaws.

7.3-7 Failure to Successfully Complete Hospital-Sponsored Training Programs Related to Electronic Medical Record (EMR) and Related Clinical System Implementation, or other Hospital Required Training Programs

Practitioners are required to successfully and timely complete any Hospital- required training programs related to EMR and clinical system implementation, or other Hospital required (non-optional) training programs, pass any related program examination or opt-out examination, and submit required program documentation. Practitioners that have already received such training at another facility, or who are permitted by the Hospital not to utilize the EMR, may be exempt from such requirements.

(a) Suspension. Whenever a practitioner fails for more than thirty (30) days following a written reminder to complete Hospital sponsored training programs related to EMR or related clinical system implementation, or any other Hospital required (non-optional) training programs, pass any related program examination or opt-out examination, and/or submit required program documentation, the practitioner's Medical Staff membership and clinical privileges at the Hospital (as applicable) may be, in the discretion of the MEC or Governing Board, administratively suspended. The practitioner shall have no right to a hearing (if applicable) or other due process,

and no notice is required, as a prerequisite to the suspension of the practitioner's Medical Staff membership and clinical privileges (as applicable). The practitioner shall remain suspended until such time as the practitioner provides reliable evidence to the MEC and CEO that the practitioner has fully completed the outstanding program and/or program documentation (as applicable).

(b) Voluntary Resignation. In the event the practitioner remains suspended pursuant to this Section for a period greater than sixty (60) days, and unless the Governing Board determines that there is good cause to make an exception, the practitioner shall be deemed to have voluntarily resigned his or her Medical Staff membership and clinical privileges (as applicable), without right of hearing, appeal or other due process (if applicable). In such event, the practitioner may reapply for Medical Staff membership or clinical privileges (as applicable) as a new applicant, pursuant to the procedures set forth in the Medical Staff Bylaws. However, the applicant must complete any program and/or program documentation (as applicable) that gave rise to the prior voluntary resignation before the applicant is eligible to reapply.

7.3-8 Failure to Provide Requested Information

Members of the Medical Staff are required to provide certain expirable items and other information to the Hospital and Medical Staff.

(a) Expirables. In the event a practitioner fails to timely provide the Hospital with a current and/or updated copy of his/her Indiana license to practice or other legal credential required for practice, Indiana Controlled Substance Registration, Federal DEA certificate, proof of professional liability insurance coverage and limits, or any other expirable item required by the Hospital or Medical Staff Bylaws, Rules, Regulations, or policies, the practitioner's Medical Staff membership and clinical privileges at the Hospital (as applicable) shall be immediately suspended. The practitioner shall have no right to a hearing (if applicable) or other due process, and no notice is required, as a prerequisite to the suspension of the practitioner's Medical Staff membership and clinical privileges (as applicable). The practitioner shall remain suspended until such time as the practitioner provides reliable evidence to the MEC and CEO that the practitioner has appropriately provided the expirable item.

(b) Information Requested by MEC or Governing Board. Except in the context of OPPE, which is addressed below, if the MEC (or designee) or the Governing Board (or designee) requests, in writing, that a practitioner provide information that is relevant to a peer review investigation, credentialing process, or FPPE, and the practitioner fails to provide such information within thirty (30) days of the written request (unless additional time is extended by the MEC or Governing Board, as applicable, for good cause, the practitioner's Medical Staff membership and clinical privileges at the Hospital (as applicable) may be, in the discretion of the MEC or Governing Board, administratively suspended. The practitioner shall have no right to a hearing (if applicable) or other due process, and no

notice is required, as a prerequisite to the suspension of the practitioner's Medical Staff membership and clinical privileges (as applicable). The practitioner shall remain suspended until such time as the requesting party receives the requested information from the practitioner.

(c) Voluntary Resignation. In the event the practitioner remains suspended pursuant to this Section for a period greater than sixty (60) days, and unless the Governing Board determines that there is good cause to make an exception, the practitioner shall be deemed to have voluntarily resigned his or her Medical Staff membership and clinical privileges (as applicable), without right of hearing, appeal, or other due process (if applicable). In such event, the practitioner may reapply for Medical Staff membership or clinical privileges (as applicable) as a new applicant, pursuant to the procedures set forth in the Medical Staff Bylaws. However, the applicant must provide any expirable or information that gave rise to the prior voluntary resignation before the applicant is eligible to reapply.

7.3-9 OPPE and Low/No Volume Providers

All practitioners at the Hospital are required to participate in OPPE, with the exception of Administrative staff. Further, all such practitioners are required to maintain a sufficient degree of volume/activity at the Hospital so as to permit meaningful evaluation of their performance through OPPE.

(a) Request for OPPE Data. In the event a Department Chairperson or the MEC determines that a practitioner has not demonstrated sufficient volume/activity at the Hospital over the six (6) month period preceding the review to permit meaningful OPPE, the Department Chairperson or MEC (or their respective designees) may request in writing that the practitioner promptly provide, or cause to be provided, (authenticated) information/data from the practitioner's primary practice location(s)

(b) Failure to Provide OPPE Data/Voluntary Resignation. In the event the Department Chairperson or MEC (as applicable) does not receive information/data that has been requested of a practitioner (pursuant to the preceding subsection) within sixty (60) days of the written request, unless additional time is extended by the Department Chairperson or MEC (as applicable) for good cause, the practitioner's failure to provide the information/data, or to cause the information/data to be provided (as applicable), shall be interpreted as, and therefore constitute, the practitioner's voluntary resignation of Medical Staff membership and clinical privileges at the Hospital (as applicable).

(c) No Volume or Clinical Activity/Voluntary Resignation. In the event a practitioner (that is not on an approved leave of absence) does not exercise his/her clinical privileges at the Hospital, and therefore demonstrates no volume/activity at the Hospital, over the course of two consecutive six (6) month periods for review (i.e. – twelve (12) consecutive months), then the practitioner's failure to exercise his/her clinical privileges shall be interpreted as, and therefore constitute, the practitioner's voluntary resignation

of Medical Staff membership and clinical privileges at the Hospital (as applicable).

(d) Reapplication. A practitioner that resigns Medical Staff membership and/or clinical privileges (as applicable) by operation of this section shall be permitted to reapply for Medical Staff membership and/or clinical privileges (as applicable) as an initial applicant unless additional facts and circumstances exist that, pursuant to the Hospital or Medical Staff Bylaws, Rules, Regulations or Policies, or applicable law or accreditation standards, would preclude such application.

7.3-10 Exclusive Contracting

Notwithstanding anything herein that could be construed to the contrary, application or re-applications for membership and/or clinical privileges related to Hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the Hospital. Similarly, the Medical Staff membership and clinical privileges of any currently privileged practitioner at the Hospital, who renders services covered by an exclusive agreement, but who is not a party to or subject of that agreement, shall automatically/administratively resign as of the effective date of the exclusive agreement. In such event, the practitioner shall be eligible to reapply as an initial applicant upon the expiration or termination of the exclusive agreement.

ARTICLE VIII

Hearings and Appellate Review

Preamble

The Board of Directors, Medical Staff and any committees thereof, in order to conduct professional peer review activities, hereby constitute themselves as peer review committees and professional review bodies committees as defined by the Indiana Peer Review Act and the federal and state statutes. The purpose of this article is to provide a mechanism through which a fair hearing and appeal might be provided to all physicians and allied health care providers who are afforded such due process rights under these bylaws and who have privileges or are applying for privileges at the hospital. These procedures are intended to comply with the Federal Health Care Quality Improvement Act of 1986 and the Indiana Peer Review Act. As such, any action taken pursuant to this article shall be in the care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care in the hospital), only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and the hearing procedures are afforded to any physician or allied health care provider involved (except where time will not permit such adequate notice and hearing procedures to be followed in order to prevent imminent danger to the health of any individual); and only in the reasonable belief that the action was warranted by the facts known after a reasonable effort has been made to obtain the facts. All persons participating on or communicating to the Board, the Medical Staff or any committee thereof shall be immune, to the full extent permitted by the law, from any cause of action for any actions done in good faith.

8.1 General Provisions

8.1-1 Exhaustion of Remedies

If adverse or professional review action described in section 8.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these bylaws before resorting to legal action.

8.1-2 Application of Article

(a) For purposes of this article, the term “member” may include “applicant” as it may be applicable under the circumstances.

(b) Under section 5.5-7 (a) (2) of these bylaws, circumstances may arise in which an initial hearing is provided by the Board of Directors. In such cases, the procedures set forth herein for hearings before the hearing committee shall generally, apply to hearings before the board, except as reasonably modified by the Board.

(c) Members who are directly under contract with the hospital in a medical-administrative capacity or in closed departments, or members whose staff membership is contingent upon a faculty appointment, shall be subject to

the procedural rights specified in Article VIII except as may be modified by contract with the hospital.

8.2 Grounds for Hearing

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

(a) Denial of medical staff membership.

(b) Denial of requested advancement in staff membership status or category.

(c) Denial of medical staff re-appointment.

(d) Involuntary change of medical staff category.

(e) Suspension of staff membership.

(f) Revocation of medical staff membership.

(h) Denial of requested clinical privileges excluding temporary privileges, except as modified by 6.4-3(e).

(i) Involuntary reduction of current clinical privileges for a period longer than fourteen (14) days.

(I) Suspension of clinical privileges for a period longer than fourteen (14) days.

(j) Termination of all clinical privileges.

(k) Involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional or associate status and section 6.3).

8.3 Requests for Hearing

8.3-1 Notice of Action or Proposed Action

In all cases in which professional review action has been taken or a recommendation made as set forth in section 8.2, the committee taking such action or making such recommendation shall give the member prompt notice of the recommendation or professional review action and notice of the right to request a hearing pursuant to section 8.3-2. The notice must state the following information:

(a) 1. That a professional review action has been proposed to be taken against the member;

2. The reason for the proposed action;

(b) 1. That the member has a right to request a hearing on proposed action;

2. In a time limit (of not less than thirty [30] days within which to request such a hearing); and

(c) A summary of the rights of the hearing under section 8.4.

8.3-2 Request for Hearing

The member shall have thirty (30) calendar days following receipt of notice of such professional review action to request a hearing. The request shall be in writing, addressed to the Medical Executive Committee with a copy to the Board of Directors. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or professional review action involved as final.

8.3-3 Time and Place for Hearing

(a) Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and give notice to the member of the time, place and date of the hearing. Unless extended by the hearing committee or waived by the member, the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than forty-five (45) calendar days from the date of the receipt of the request by the Medical Executive Committee for a hearing.

(b) When the request is received from a member who is under summary suspension, the hearing shall be held as soon as the arrangements can be reasonably made, but not to exceed fifteen (15) calendar days from the date of receipt of the request unless the member requests up to thirty (30) days prior notice to which he is entitled under the Health Care Quality Improvement Act of 1996.

8.3-4 Notice of Charges

Together with the notice of hearing, the Medical Executive Committee shall state clearly and concisely in writing the reason for the adverse professional review action taken or recommended, including the acts or omissions with which the member is charged and a list of the charts in question, where applicable. The notice of hearing shall include a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee. In the event witnesses not otherwise named in the notice of hearing become available or are anticipated to give testimony or evidence in support of the Medical Executive Committee, the names and address of these additional witnesses shall be promptly forwarded to the affected physician. The affected physician has a right to review any documents, charts, or written material that may be used to support the charges against him. A reasonable fee may be charged to the member for the production of such documents. The Medical Executive Committee is entitled to the same right to receive a list of the witnesses expected to testify on behalf of the affected physician as well as any documents, charts, or written material that may be used by the physician at the hearing.

8.3-5 Hearing Committee

When a hearing is requested, the board shall appoint a hearing committee, which shall

be composed of not less than three (3) members of the medical staff who shall not have actively participated in the consideration of the matter leading up to the recommendation. Knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the hearing committee. In the event it is not feasible to appoint a hearing committee from the active medical staff, the Board may appoint members from other staff categories or physicians or providers who are not members of the medical staff. Such appointment shall include the designation of a chairman. If feasible, membership on the hearing committee shall consist of at least one member who shall have the same healing arts, licensure or specialty as the affected member. A majority of the members of the hearing committee shall be physicians.

8.3-6 Failure to Appear or Proceed

Failure without good cause of the member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or professional review actions involved or taken and shall constitute a waiver of any rights under this article.

8.3-7 Postponements and Extensions

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

8.4 Hearing Procedure

8.4-1 Prehearing Procedure

(a) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chairman of the hearing committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

8.4-2 Representation

The hearings provided for in these bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character. The member shall be entitled to be accompanied by and represented at the hearing by an attorney or other person of his choice. The Medical Executive Committee or the committee or representative thereof bringing the professional review action may appoint an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions.

8.4-3 The Hearing Officer

The Board of Directors shall appoint a hearing officer, not a member of the hearing committee, to preside at the hearing. The hearing officer may be an attorney at law

qualified to preside over a quasi-judicial hearing. The hearing officer must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure or the admissibility of evidence. If the hearing officer determines that either side in the hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the hearing committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

8.4-4 Record of the Hearing

A complete and accurate record of the hearing proceedings shall be made. The cost of such record shall be borne by the Hospital. The Hearing Committee shall maintain a record of the hearing by a court reporter who is present during the proceedings. The Hearing Committee shall require evidence to be taken only on sworn oath or affirmation administered by any person authorized to administer such oaths in the State of Indiana. Each party shall be entitled, at its own expense, to receive a copy of the hearing transcript.

8.4-5 Rights of the Parties

Within reasonable limitations, both sides at the hearing have the right:

1. To representation by an attorney or other person of choice;

2. To have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof;

3. To call, examine and cross-examine witnesses;

4. To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; and

5. To submit a written statement at the close of the hearing. Furthermore, upon completion of the hearing, the physician has the right:

6. To receive the written recommendation of the committee, including a statement of the basis for the recommendation, and

7. To receive the written decision of the hospital, including a statement of the basis for the decision.

8.4-6 Miscellaneous Rules

Judicial rules of evidence and procedure relating to the conduct of the hearing,

examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this article. Any relevant evidence, including hearsay, may be admitted at the discretion of the hearing officer. The hearing committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the hearing committee may request or permit both sides to file written arguments.

8.4-7 Burdens of Presenting Evidence and Proof

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

8.4-8 Adjournment and Conclusion

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

8.4-9 Basis for Decision

The decision of the hearing committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and testimony.

8.4-10 Decision of The Hearing Committee

Within (15) days after final adjournment of the hearing, the hearing committee shall make a recommendation which shall be accompanied by a report in writing stating the basis of such decision and shall be delivered to the Medical Executive Committee. A copy of said decision shall also be forwarded to the Administrator, the Board of Directors, and to the member. The report shall contain a concise statement of the reasons in support of the recommendation. The recommendation of the hearing committee shall be subject to such rights of appeal or review as described in these bylaws.

8.5 Appeal

8.5-1 Time for Appeal

Within (10) days after receipt of the recommendation of the hearing committee, either the member or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Administrator, the Hearing Officer, the affected member, the Medical Executive Committee and the

Board of Directors. If a request for appellate review is not requested within such period, the professional review action or recommendation shall thereupon become final, subject to approval by the Board of Directors.

8.5-2 Grounds for Appeal

A written request for an appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice; or (b) the decision was not supported by substantial evidence based upon the hearing record.

8.5-3 Time, Place and Notice

If an appellate review is to be conducted, the appeal board shall, as appointed by the Board of Directors, within (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of time, place and date of the appellate review. The date of the appellate review shall not be less than (30) nor more than (60) days from the date of such notice: provided, however, that when a request for appellate review concerns a member who is under summary suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed (15) days from the date of the notice. The time for appellate review may be extended by the appeal board for good cause. Notwithstanding the above time frames, in no event shall the appellate review be held less than five (5) days after both parties have received a copy of the record of the proceeding at the hearing committee level.

8.5-4 Appeal Board

The Board of Directors may sit as the appeal board or it may appoint an appeal board, which shall be composed of not less than three (3) members of the board of directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

8.5-5 Appeal Procedure

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the hearing committee. Each party shall have the right to be represented by legal counsel in connection with the appeal, to present a written statement in support of his position on appeal and, in its sole discretion, the appeal board may allow each party or representative to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Board of Directors its' written recommendations as to whether the board of directors should affirm, modify, or reverse the hearing committee's recommendation.

8.5-6 Decision

(a) Except as otherwise provided herein, within (30) days after the conclusion of the appellate review proceeding, the Board of Directors shall render a decision in writing and shall forward copies thereof to each party involved in the professional review action.

(b) The Board of Directors may affirm, modify, or reverse the recommendation of the hearing committee.

(c) In the event the decision of the Board of Directors is unfavorable to the applicant, that professional review action shall become final. In the event the decision is favorable, that professional review action shall also become final.

8.5-7 Right to One Hearing

No member shall be entitled to more than one evidentiary hearing and one appellate review on any matter which has been the subject of an adverse professional review action or recommendation.

8.6 Exceptions to Hearing Rights

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in section 7.3-1 (a). In other cases, described in section 7.3-1 and 7.3-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the Indiana Controlled Substance Board and/or DEA was unwarranted, but only whether the member may continue practice in the hospital with those limitations imposed.

8.7 Reporting Requirements

8.7-1 Any final adverse professional review action by the Board of Directors or other professional review action or medical malpractice action or claim required to be reported under the Federal Health Care Quality Improvement Act or any state law or regulation shall be reported to the Medical Licensing Board of Indiana and the Secretary of the Department of Health and Human Services or his designee in accordance with the State Peer Review Act and the Federal Health Care Quality Improvement Act of 1986.

ARTICLE IX

Officers

9.1 Officers of the Medical Staff

9.1-1 Identification

The officers of the medical staff shall be the Chief of Staff, Vice Chief of Staff (or Chief Of Staff-elect), and Secretary-Treasurer.

9.1-2 Qualifications

Officers must be members of the active medical staff at the time of their nominations and election and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

9.1-3 Elections

(a) Officers shall be elected at the meeting prior to the last meeting of the Medical Executive Committee/Medical Staff. Only members of the Active Medical Staff shall be eligible to vote. Voting may be by voice or by ballot according to the desires of the active medical staff. In the situation where there are three or more candidates and no candidate receives a majority, successive balloting shall take place. The candidate receiving the fewest votes will be omitted from each successive slate until a majority vote is obtained by one candidate.

(b) The nominating committee shall consist of three (3) members of the Active Medical Staff appointed by the Chief of the Medical Staff. The committee shall offer one or more nominees for each office.

(c) Nominations may also be made from the floor at the time election is held.

9.1-4 Term of Elected Office

Each officer shall serve a one-year term, commencing on the first day of the medical staff calendar year following his election. Each officer shall serve in office until the end of his tenure, unless he shall sooner resign or be removed from office.

9.1-5 Recall of Officers

Except as otherwise provided, recall of a medical staff officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least one-third of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the medical staff members eligible to vote for medical staff officers who actually cast votes at the special meeting in person or by mail ballot.

9.1-6 Vacancies in Elected Office

Vacancies in the office occur upon the death, disability, resignation, or removal of an officer, or such officer's loss of membership in the medical staff. Vacancies, other than that of Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of the Chief of Staff, the then Vice Chief of Staff shall serve out the remaining term or until a new Chief of Staff is elected and shall immediately convene the nominating committee to decide promptly upon nominees for the office of the vice Chief of Staff. Such nominees shall be reported to the Medical Executive Committee and to the Medical Staff. A special election may be held to fill the position at the next regular staff meeting. Alternatively, if there is a vacancy in the office of Vice Chief of Staff, the office need not be filled by election; the Medical Executive Committee may appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of Chief of Staff.

9.2 Duties of Officers

9.2-1 Chief of Staff

The Chief of Staff shall serve as the Chief Officer of the Medical Staff. The duties of the Chief of Staff shall include, but are not limited to:

(a) Enforcing the medical staff bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where professional review action has been requested or initiated;

(b) Calling, presiding at, and being responsible for the agenda of all meetings of the medical staff;

(d) Chief of Staff shall serve as chairman of the Medical Executive Committee.

(e) Serving as an ex-officio member of all other staff committees, without vote, unless his membership in a particular committee is required by these bylaws;

(f) Appointing members for all standing and special medical staff, liaison, or multidisciplinary committees, except where otherwise provided by these bylaws and except where otherwise indicated, designating the chairman of these committees;

(g) Representing the views and policies of the Medical Staff to the Board of Directors and to the Administrator;

(h) Being a spokesman for the Medical Staff in external professional and public relations;

(i) Performing such other functions as may be assigned to him by these bylaws, the Medical Staff, or the Medical Executive Committee; and

(l) Serving on liaison committees with the Board of Directors and Administration, as well as outside licensing and accreditation agencies.

9.2-2 Vice Chief of Staff

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee and of the Active Medical Staff, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these bylaws, or by the Medical Executive Committee.

9.2-3 Secretary-Treasurer

The secretary-treasurer shall be a member of the Medical Executive Committee. The duties shall include, with the assistance of the hospital administration, but are not to be limited to:

(a) Maintaining a roster of members;

(b) Keeping accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings;

(c) Calling meetings on the order of the Chief of Staff or Medical Executive Committee;

(d) Attending to all appropriate correspondence and notices on behalf of the Medical Staff;

(e) Receiving and safeguarding all funds of the medical staff;

(f) Excusing absences from meetings on behalf of the Medical Executive Committee; and

(g) Performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

ARTICLE X

Clinical Departments

10.1 Organization of Clinical Departments

The medical staff shall be divided into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a chairman selected and entrusted with the authority, duties and responsibilities specified in section 10.5. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments.

10.2 Current Departments

The Current Departments are:

(a) Medical/Family Practice/Pediatrics/Emergency Medicine/Gynecology/ Occupational Medicine

(b) Surgical/Anesthesia

10.2-1 Medical Department

The Special Functions Of The Medical Department Shall Be:

(a) To review medicine related incident reports by any other departments or committees.

(b) To review adverse drug reactions referred by any other departments or committees.

(c) Development of a screening mechanism for continuous monitoring based upon pre-established criteria may be established.

10.2-2 Surgical Department

The special functions of the surgery department shall be:

(a) To evaluate the appropriateness of blood transfusions.

(b) To develop proposed policies and procedures for the screening, distribution, handling and administration of blood and blood components.

(c) To review surgical cases in which a specimen is removed as well as cases in which no specimen is removed. A screening mechanism based upon pre-established criteria may be established.

10.3 Assignment to Departments

Each member shall be assigned membership in at least one department, but may be granted membership and/or clinical privileges in other departments consistent with their clinical privileges granted.

10.4 Functions of Departments

The general function of each department shall include:

(a) Assist in facilitating OPPE and FPPE by conducting patient care reviews for the purpose of monitoring, analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The department shall routinely collect information about the important aspects of patient care provided in the department, periodically assess this information and develop objective criteria for use in evaluating patient care, patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work subject to such review is a member of that department;

b) Recommending to the credentials committee and the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department;

c) Evaluating and making appropriate recommendations regarding the qualifications of the applicants seeking appointment or re-appointment and clinical privileges within that department;

d) Conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice;

e) Reviewing and evaluating departmental adherence to: (1) medical staff policies and procedures; and (2) sound principles of clinical practice which comply with the applicable standard of care;

f) Coordinating patient care provided by the department's members with nursing and ancillary patient care services;

g) Submitting written reports to the Medical Executive Committee concerning: (1) the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and the hospital;

(h) Meeting at least four times per year, or as called by the Department Chair/Chief Of staff, for the purpose of considering patient review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions;

(i) Establishing such committees or other mechanisms as are necessary and

desirable to perform properly the functions assigned to it, including proctoring and establishing protocols;

(j) Accounting to the Medical Executive Committee for all professional and medical staff administrative activities within the department; and

(k) Formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities, subject to approval by the Medical Executive committee and the Medical Staff.

10.5 Departmental Heads

10.5-1 Qualifications

Each department shall have a chairman and vice-chairman who shall be members of the active medical staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the department.

10.5-2 Selection

Department chairman and vice-chairman shall be appointed by the Chief of Staff.

10.5-3 Term of Office

Each department chairman and vice-chairman shall serve a one-year term which coincides with the medical staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their medical staff membership or clinical privileges in that department. Department officers shall be eligible to succeed themselves.

10.5-4 Removal

After appointment, removal of a department chairman or vice-chairman from office may occur for cause by two-thirds vote of the Medical Executive Committee and a two-thirds vote of the department members eligible to vote on departmental matters.

10.5-5 Duties

Each chairman shall have the following authority, duties and responsibilities, and the vice-chairman, in the absence of the chairman, shall assume all of them and both shall otherwise perform such duties as may be assigned to him:

(a) Act as presiding officer at departmental meetings;

(b) Report to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the department;

(d) Assist in facilitating OPPE and FPPE as outlined in the Hospital's OPPE and FPPE policies, and generally monitor the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee;

(e) Develop and implement departmental programs for retrospective patient care review, on-going monitoring of practice, credentials review and privileges delineation, medical education, utilization review and quality assurance;

(f) Be a member of the Medical Executive Committee, and give guidance on the overall medical policies of the medical staff and hospital and make specific recommendations and suggestions regarding his department;

(g) Transmit to the Medical Executive Committee the department's recommendations concerning appointment and classification, re-appointment, criteria for clinical privileges, monitoring of specific services, and professional review action with respect to persons with clinical privileges in his department.

(h) Endeavor to enforce the medical staff bylaws, rules, policies and regulations within his department;

(i) Implement within his department appropriate actions taken by the Medical Executive Committee;

(j) Participate in every phase of administration of his department, including cooperation with the nursing service and the hospital administration in matters such as personnel, supplies, special regulations, standing orders and techniques;

(k) Assist in the preparation of such annual reports, including budgetary planning, pertaining to his department as may be required by the Medical Executive Committee;

(l) Recommend delineated clinical privileges for each member of the department; and

(m) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or Medical Executive Committee.

ARTICLE XI

Committees

11.1 Designation

The committees described in this article shall be the standing committees of the Medical Staff and where appropriate shall be structured to qualify as a peer review committee under the state and federal peer review immunity statutes. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the chairman and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee. Medical Staff Committees shall be responsible to the Medical Executive Committee and ultimately to the Board of Directors. The majority of members on any of these committees of the medical staff that perform any peer review functions shall be medical staff members.

11.2 General Provisions

11.2-1 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of one year, and shall serve until the end of the period or until the member's successor is appointed, unless the member shall sooner resign or be removed for the committee.

11.2-2 Removal

If a member of a committee ceases to be a member in good standing of the Medical Staff, or loses employment or a contract relationship with the hospital, suffers a loss or significant limitation of clinical privileges, or if any other good cause exists, that member may be removed by the Medical Executive Committee.

11.2-3 Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided, however, that if an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

11.3 Medical Executive Committee

11.3-1 Composition

The Medical Executive Committee shall consist of the following persons:

(a) The officers of the medical staff;
(b) The department chairmen;
(c) The Administrator of the hospital as an ex-officio member;

(d) The Chief Nursing Officer as an ex-officio member; and
(e) At the discretion of the Chief of Staff, other members may be appointed to this committee.

11.3-2 Duties

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

(a) Representing and acting on behalf of the Medical Staff in the intervals between medical staff meetings, subject to such limitations as may be imposed by these bylaws;

(b) Coordinating and implementing the professional and organizational activities and policies of the medical staff.

(c) Receiving and acting upon reports and recommendations from medical staff departments, divisions, committees, and assigned activity groups;

(d) Recommending action to the Board of Directors on matters of a medical-administrative nature;

(e) Evaluating the medical care rendered to patients in the hospital;

(f) Participating in the development of all medical staff and hospital policy, practice, and planning;

(g) Reviewing the qualifications, credentials, performance and professional competence and character of applicants and staff members and making recommendations to the Board of Directors regarding staff appointments and re-appointments, assignments to departments, clinical privileges, and professional review action;

(h) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in the medical staff professional review or review measures when warranted;

(i) Taking reasonable steps to develop continuing education activities and programs for the medical staff;

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

(j) Reporting to the Medical Staff at each regular staff meeting;

(k) Assisting in the obtaining and maintaining of accreditation;

(l) Developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster:

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

(o) Reviewing the quality and appropriateness of services provided by contract physicians.

(p) Facilitate OPPE and FPPE as set forth in the Hospital's OPPE and FPPE policies.

11.3-3 Meetings

The Executive Committee shall meet as often as necessary, but at least six months of the year and shall maintain a record of its proceedings and actions.

11.4 Credentials Committee

11.4-1 Composition

The Chief of Staff shall appoint two or more members to serve as the credentials committee to carry out the duties set forth below and in these bylaws on behalf of the Medical Staff. The credentials committee may assign one of its members to perform the initial review, investigation and verification of an applicant's qualifications, who upon completion of such review, will report his findings to the credentials committee for further action as provided herein and in these bylaws.

11.4-2 Duties

The Credentials Committee Shall:

(a) Review, investigate and evaluate the qualifications of each physician and provider applying for initial appointment, re-appointment, clinical privileges, and/or modification thereof and in connection therewith, obtain and consider the recommendations of the appropriate departments;

(b) Submit required reports and information on the qualifications of each physician and provider applying for membership or particular clinical privileges including recommendations to the Medical Executive Committee with respect to appointment, membership category, department affiliation, clinical privileges and special conditions;

(c) Investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, or professional character or competence of any applicant, Medical Staff member or provider; and

(d) Submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.

11.4-3 Meetings

The credentials committee shall meet as often as necessary at the call of its chairman. The committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

11.5 Performance Improvement Committee (PIC)

11.5-1 Composition

Members of the PIC shall consist of representatives from the Medical Staff appointed annually by the Chief of Staff. Other representatives on this committee shall be department directors of various hospital departments as deemed necessary and representatives from each performance improvement function team.

PI function teams representing – Home Health, SNF, Lab, Information Management; Patient Rights & Organizational Ethics; Education; Management of Human Resources; Surveillance, Prevention & Control of Infection; Assessment of patients/ care of patients/continuum of care/nursing; management of environment of care; leadership/governance/management and pharmacy ad hoc committee will carry out routine functions at the performance improvement committee. A chairman, co-chairman, vice-chairman, and vice co-chairman will jointly chair this committee.

11.5-2 Duties

The Performance Improvement Committee shall have the following responsibilities:

(a) Develop and implement the performance improvement processes both intra and interdepartmentally;

(b) Refer problems to appropriate departments/committees for further assessment and improvement;

(c) Monitor performance improvement activities:
    1. Review and approve monitoring and evaluation plans annually
    2. Review of monitoring results from all hospital departments/committees as scheduled, and;
    3. Review of findings to determine appropriateness and effectiveness of actions;

(d) Report findings of performance improvement teams to the appropriate groups within the organization;

(e) Ensure that relevant results for the medical staff profiles are reported to medical staff services;

(f) Report activities to the Executive Committee of the Medical Staff and the Administrator, with recommendations for appropriate action when indicated;

(g) Evaluate the performance improvement program no less than annually;

(h) Review the performance improvement plan no less than annually and revise as necessary.

11.5-3 Meetings

The committee shall meet as often as necessary at the call of its chairmen, but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the executive committee and the board of trustees.

11.6 Pharmacy Ad Hoc Committee

11.6-1 Composition

Ad Hoc Committee Formed By the PIC.

Representation includes medical staff member appointed annually, pharmacy services, acute nursing, surgical services, clinical dietitian, and support services

11.6-2 Duties

The duties of the pharmacy ad hoc committee shall include:

(a) Assisting in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;

(b) Advising the medical staff and the pharmaceutical service on matters pertaining to the choice of available drugs;

(c) Making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(d) Periodically developing and reviewing a formulary or drug list for use in the hospital;

(e) Evaluating clinical data concerning new drugs or preparations requested for use in the hospital;

(f) Establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

(g) Maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities; and

(h) Reviewing significant adverse drug reactions.

11.6-3 Meetings

The committee shall meet as often as necessary at the call of its chairman. Routine functions of this committee shall be covered in the Performance Improvement Committee. It shall maintain a record of its proceeding and shall report its activities and recommendations to the Medical Executive Committee.

11.7 Infection Control Committee

11.71 Composition

Members include – medical staff representative(s) and representation from the acute facility, surgical services, pharmacy, dietary, environmental services, and support services.

11.7-2 Duties

The Duties Of The Infection Control Committee Shall Include:

(a) Developing a hospital wide infection control program and maintaining surveillance over the program;

(b) Developing a system for reporting, identifying and analyzing the incidence and cause of Nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

(c) Developing and implementing a preventive and professional review program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

(a) Developing written polices defining special indications for isolation requirements;

(b) Coordinating action on findings from the medical staff's review of the clinical use of antibiotics;

(c) Acting upon recommendations related to infection control received from the Chief of Staff, the Medical Executive Committee, departments and other committees; and

(f) Reviewing sensitivities of organisms specific to the facility.

11.7-3 Meetings

The Infection Control Committee shall meet as often as necessary but at least quarterly, at the call of its chairman. Routine functions of this committee shall be covered in the Performance Improvement Committee. it shall maintain a record of its proceedings and shall submit reports of its activities and recommendation to the Medical Executive Committee.

11.8 Hospital Impaired Physician Committee

The Hospital Impaired Physician ("HIP") committee is formed to improve the quality of care and promote the competence of the Medical Staff, and there is hereby established a Hospital Impaired Physician Program (hereby referred to as the "Program") within the hospital. The Medical Staff hereby establishes the HIP Committee as a Peer Review Committee to conduct the Program. This Program is entirely independent of any other committee and is entirely separate from any disciplinary or enforcement activities established or authorized by these bylaws. Members of the medical staff, providers, Hospital personnel, or any other caring and interested persons are encouraged to report to the committee any instance of suspected functional and professional impairment because of alcoholism or drug dependence, or mental, physical or aging problems that have or could give rise to injury to a patient or could affect quality of care.

11.8-1 Composition

The HIP Committee shall be composed of no less than three active members of the medical staff who shall be appointed by the Chief of Staff annually. A majority of the HIP Committee shall be Medical Staff members. Except for initial appointments, each member shall serve a term of two years, and the terms shall be staggered to ensure continuity and experience.

11.8-2 Duties

The Duties Of The HIP Committee Shall Include:

(a) To be the identified point within the hospital where early informal report concerning suspected physician impairment can be delivered for consideration;

(b) To seek additional information, evaluate and substantiate to determine if significant impairment exists;

(c) To confront, intervene, and provide assistance in obtaining treatment for the impaired physician;

(d) To be the recovering physician's advocate and facilitate rehabilitation and reentry into practice without humiliation or rejection;

(e) To monitor recovery where necessary; and

(e) To educate the Medical Staff, hospital personnel, and families of physicians concerning physician impairment.

11.8-3 Intervention Teams

Two or more Medical Staff members shall be selected by the committee to be an adjunct to the committee and act as an ad hoc intervention team for each impaired physician to be confronted. The intervention team is to confront the physician with the committee's findings in a manner that shall maintain confidentiality with respect to the sources of its information, unless otherwise required by law, and shall provide

assistance to enter into a treatment program which meets the requirements of 844 iac 5-1-2(g) and shall supervise and monitor such treatment.

11.8-4 Monitoring

The committee will select a Medical Staff member who is responsible to the committee to monitor the recovering physician's progress after reentry into practice wherever necessary and shall report to the committee regarding the same. This improves the recovering physician's credibility and is an adjunct to ensure patient protection.

11.8-5 Meetings

The committee shall meet as often as necessary at the call of its chairman, Chief of Staff, Administrator, or Board Chairman. Minutes of the activities of the committee shall be recorded and identified as confidential and handled accordingly.

11.8-6 Policies

The committee shall have no disciplinary powers except that it shall report to the appropriate medical staff committee and/or Medical Licensing Board of Indiana as required under the Indiana and federal peer review statutes and the Medical Licensing Board regulations on the standards of professional conduct and competent practice of medicine, 844 IAC5-1 et. seq. The committee will act as the physician's advocate. All contacts or sources of information, to include physician contacts, shall be confidential.

11.9 Ethics Committee

11.9-1 Composition

The Ethics Committee shall be composed of eight (8) members. Appointments will be made yearly. The committee shall consist of the following voting members:

1. Two (2) members of the Active Medical Staff appointed by Chief of Staff.
2. One (1) member of Administration or person designated by administration.
3. One (1) member of nursing service.
4. One (1) member of the community at large appointed by the board or administration.
5. One (1) member of the volunteer chaplains' association appointed by administration.
6. One (1) member of the hospital board.

Non-voting members shall include a representative from social service and other members of the medical staff with expertise in particular areas, as well as other members of the hospital community and community in general with specialized areas of interest or varying points of view, who shall be called upon freely by the committee to aid in its deliberations.

11.09-2 Duties

The Ethics Committee Shall:

1. Serve in an advisory capacity to resolve conflicts, make recommendations, and encourage education regarding medical ethics and patient care problems. Any patient care decision would remain with the patient, the patient's family, or any other interested party, and the patient's attending physician.

2. Refer ethical problems related solely to physicians to the Credentials Committee, Impaired Physician's Committee, or clinical departments.

3. Approach inquiries brought before the committee drawing upon expert knowledge and prior experience.

Serve as a peer review committee within the meaning of the Indiana Peer Review Statute and a professional review body within the meaning of the federal health care quality improvement act of 1986. Therefore, all deliberations shall remain absolutely confidential.

11.09-3 Meetings

The Ethics Committee shall meet at least quarterly, and as deemed necessary by members of the committee, as well as on short notice as necessitated by questions and problems brought to the committee. It shall maintain a record of its activities and report to the Medical Executive Committee and to the Board through Hospital Administration.

11.10 Nominating Committee

11.10-1 Composition

The nominating committee shall consist of at least three members of the Medical Staff who shall be appointed by the Chief of Staff.

11.10-2 Duties

The nominating committee shall announce their slate of officers at the meeting prior to the last meeting of the medical staff year. This will enable the new Chief of Staff to set up his appointments before the new medical staff year.

11.10-3 Meetings

The nominating committee shall meet as often as necessary and report to the Medical Executive Committee.

ARTICLE XII

Meetings

12.1 Meetings

12.1-1 Annual Meetings

There will be an annual meeting which will be held in conjunction with the board of trustees. It is highly recommended that all active members attend the annual meeting.

12.1-2 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee or shall be called upon the written request of 20% of the members of the Active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the members of the staff, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.2 Committee and Departmental Meetings

12.2-1 Regular Meetings

Except as otherwise specified in these bylaws, the chairman of the committees and departments may establish the times for the holding of regular meetings. The chairmen shall make every reasonable effort to ensure the meeting dates are disseminated to members with adequate notice.

12.2-2 Special Meetings

A special meeting of any Medical Staff committee and department may be called by the chairman thereof, the Medical Executive Committee, or the Chief of Staff, and shall be called by written request of one-third of the current members, eligible to vote.

12.3 Quorum

12.3-1 Staff Meetings

The presence of two-thirds of the total members of the Active Medical Staff at any regular or special meeting in person shall constitute a quorum for the purpose of amending these bylaws or for the election or removal of medical staff officers. The presence of fifty percent of such members shall constitute a quorum for all other actions.

12.3-2 Department and Committee Meetings

A quorum of fifty percent of the voting members shall be required for Medical Executive/Credentials Committee meetings. For other committees and departments, a Quorum shall consist of fifty percent of the committee membership.

12.4 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. In the event that it is necessary for the medical staff to act on a question without being able to meet, the voting membership may be presented with the question by mail or other electronic means of communication and their votes returned to the Chief of Staff by same.

12.5 Minutes

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee. The minutes shall comply with the requirements of recognized accrediting agencies.

12.6 Attendance Requirements

12.6-1 Regular Attendance

Except as stated below, each member of the active and associate staff and all other members who during their term of appointment are entitled to attend meetings shall be required to attend:

(a) The annual medical staff meeting.

(b) At least fifty (50%) of all other general staff meetings duly convened pursuant to these bylaws.

(c) At least fifty (50%) percent of all meetings of each department and committee of which he or she is a member. Each member of the consulting or courtesy staff who qualify under criteria applicable to courtesy or consulting members shall be required to attend such other meetings as may be determined by the Medical Executive Committee.

12.6-2 Absence from Meetings

Any member who is compelled to be absent from any Medical Staff, department, or

committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the department or committee or the secretary-treasurer for Medical Staff meetings, failure to meet the attendance requirements may be grounds for removal from such committee or for professional review action. Committee chairman shall report such failures to the Executive Committee for action.

12.6-3 Special Attendance

At the discretion of the chairman or presiding officer, when a member's or provider's practice or conduct is scheduled for discussion at a regular department or committee meeting, the member or provider may be requested to attend. Attendance at such meeting is informal and the member shall not be entitled to any procedural rights under Article VIII. If a suspected deviation from standard clinical practice is involved, the Notice shall be given at least seven (7) days prior to the meeting and shall state a general indication of the issue involved. Failure of a member to appear at any meeting with respect to which he was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for professional review action and may be grounds for automatic suspension as determined by the Executive Committee.

12.6-4 Right of Ex-officio Members

Persons serving under these bylaws as ex-officio members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum.

12.7 Conduct of Meetings

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical or not-substantive departures from rules shall not invalidate action taken at such a meeting.

ARTICLE XIII

Confidentiality, Immunity and Releases

13.1 Authorization and Conditions

By applying for or exercising clinical privileges within this hospital, an applicant:

(a) Authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) Authorizes persons and organizations to provide information concerning such applicant to the medical staff;

(c) Agrees to be bound by the provisions of this article and to waive all legal claims against any representative of the Medical Staff membership, the continuation of medical staff membership and to the exercise of clinical privileges at this Hospital.

13.2 Confidentiality of Information

13.2-1 General

Medical Staff, department, 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. 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 a signed waiver by the affected peer review committee.

13.2-2 Breach of Confidentiality

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff members and applicants for privileges must be based on free and candid discussions any breach of confidentiality of the discussions or deliberations of medical staff departments, or committees, except in conjunction with other hospitals, professional societies or licensing authorities, is outside appropriate standards of conduct for this medical staff and will be deemed disruptive to the operations of the hospital, subject to the fair hearing procedures in Article VIII. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such professional review action as it deems appropriate.

13.3 Immunity from Liability

13.3-1 For Action Taken

Each representative of the Medical Staff and Hospital shall be exempt, and have

absolute immunity to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of his or her duties as a representative of the medical staff or hospital, or by their committees, members, agents, employees, advisors, counselors, consultants and attorneys, or any other person providing services to or through the medical staff, hospital or any committee thereof in conjunction with evaluation of an applicant or member.

13.3-2 For Providing Information

Each representative of the Medical Staff and Hospital and all third parties shall be immune, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or hospital concerning such person who is, or has been an applicant to or member of the staff or who did, or does exercise clinical privileges or provide services at this hospital.

13.4 Activities and Information Covered

13.4-1 Activities

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

(a) Applications for appointment, re-appointment, or clinical privileges;

(b) OPPE, FPPE, and other professional review investigation and action;

(c) Hearing and appellate reviews;

(d) Utilization reviews;

(e) Other department, or committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(f) Peer review committee or professional review body reports and similar reports.

13.5 Releases

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

ARTICLE XIV

General Provisions

14.1 Rules and Regulations

The Medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws, subject to the approval of the Board of Directors. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be part of these bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice or at any special meeting with notice, by a two-thirds vote of those active Medical Staff Members present. Such change shall become effective when approved by the Board of Directors. If there is a conflict between the bylaws and the rules and regulations, the bylaws shall prevail.

14.2 Dues or Assessments

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of medical staff membership, subject to the approval of the medical staff, and to determine the manner of expenditure of such funds received.

14.3 Authority to Act

Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary actions the Medical Executive Committee and Board may deem appropriate.

14.4 Division of Fees

Any division of fees by members of the Medical Staff is forbidden and any such division of fees shall be cause for expulsion from the Medical Staff.

14.5 Notices

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, and requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through the United States postal service first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable, is expeditious, and if evidence of its use is obtained. Notice to the medical staff or officers or committees thereof, shall be addressed as follows:

Name of proper title of addressee, if known or applicable name of department of committee
(c/o Medical Staff Coordinator, Chief of Staff)
Gibson General Hospital
1808 Sherman Drive
Princeton, IN 47670

Mailed notices to a member, applicant, or other party shall be to the addressee at the address that last appears in the official records of the Medical Staff of the hospital. When possible and applicable a signed receipt shall be returned to the hospital.

14.6 Amendments

These bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. A proposed amendment shall be referred to a special committee which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require a two-thirds vote of the Active Medical Staff present at any meeting where a quorum exists. Amendments so made shall be effective when approved by the Board of Directors.

14.7 Adoption

These bylaws together with the appended rules and regulations, shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous bylaws, rules and regulations, and shall become effective when approved by the Board of Directors of the Hospital.

Amendments adopted since November 1983 have been incorporated in this document.

Revisions Approved by Medical Staff	**Approval by Board of Trustees**
February 21, 1989	June, 15, 1989
January 9, 1996	February 22, 1996
May 26, 1998	May 28, 1998
May 25, 1999	May 27, 1999
March 19, 2003	March 26, 2003
March 18, 2009	March 25, 2009
May 20, 2009	May 27, 2009
June 17, 2009	June 24, 2009
July 15, 2009	July 29, 2009
September 16, 2009	September 23, 2009
March 16, 2011	March 23, 2011
November 16, 2011	December 7, 2011
December 21, 2011	January 25, 2012
May 15, 2013	May 23, 2013
July 16, 2014	July 23, 2014
January 21, 2015	January 28, 2015
February 18, 2015	February 25, 2015
October 19, 2016	October 26, 2016
February 15, 2017	February 22, 2017
May 16, 2018	May 23, 2018
May 15, 2019	May 22, 2019

Amendments adopted since November 1983 have been incorporated in this document.

Revisions Approved by Medical Staff	**Approval by Board of Trustees**
October 16, 2019	October 23, 2019
January 16, 2020	February 7, 2020
July 16, 2020	July 22, 2020
May 17, 2023	June 28, 2023
August 16, 2023	August 23, 2023
August 21, 2024	August 28, 2024
November 20, 2024	December 4, 2024