HENDRICKS REGIONAL HEALTH

MEDICAL STAFF BYLAWS

These Bylaws will be adopted by the Medical Staff annually They will be presented to the General Medical Staff at the November meeting of the General Medical Staff. The Medical Staff will be given 15 days to contact the Chairman of the Bylaws Committee with any question or recommendations. Medical Executive Committee will review at the September meeting.

The attached Bylaws SO ADOPTED: January, 1990

Revised 2/14/91
Revised 2/92
Revised 2/93
Revised 2/94
Revised 1/95
Revised/Effective 1/96
Approved 2/97
Revised/Effective 2/98
Revised/Effective 1/99
Revised/Effective 1/00
Revised/Effective 1/01
Revised/Effective 1/02
Revised/Effective 1/03
Revised/Effective 1/04
Revised/Effective 1/05
Revised/Effective 1/06
Effective 1/2007
Revised/Effective 1/2008
Revised/Effective 1/2009
Effective 1/2010
Revised/Effective 1/2011
Approved/Effective 1/2012
Revised/Effective 1/2013
Revised/Effective 1/2014
Revised/Effective 1/2016
Revised/Effective 3/2017
Revised/Effective 4/2019
Revised/Effective 10/2020
Revised/Effective 03/2022
Revised/Effective 09/2022

BYLAWS OF THE MEDICAL STAFF

OF

HENDRICKS REGIONAL HEALTH

PREAMBLE

WHEREAS, Hendricks Regional Health is an Indiana County Hospital organized under the laws of the State of Indiana; and

WHEREAS, its purpose is to serve as a general Hospital providing patient care and in-service education; and

WHEREAS, it is recognized that the members of the Medical Staff are responsible for advising the Governing Body of the Hospital on scientific and medical matters, including the monitoring of health care provided within the Hospital and the credentialing and delineation of privileges for all health care providers within the Hospital; and

WHEREAS, it is recognized that the members of the Medical Staff must accept and carry out such responsibility as the agents of the Board of Trustees in cooperation with the administration of the Hospital in order to fulfill the Hospital's obligations to its patients; and

WHEREAS, the Board of Trustees and the Medical Staff, in order to promote professional peer review activity designed to establish a stable and harmonious environment in which appropriate levels of patient care may be achieved, hereby constitute themselves as Professional Review Bodies as defined by the Health Care Quality Improvement Act of 1986 and the Indiana Peer Review Act, I.C. 34-30-15-1, and the Board and Medical Staff hereby claim all privileges and immunities afforded them by the federal and state statutes.

NOW, THEREFORE, the Physicians and Allied Health Professionals practicing in the Hospital hereby organize their efforts in carrying out these tasks in conformity with these Bylaws.

INTRODUCTION

These Medical Staff Bylaws ("Bylaws") shall not in any manner be deemed to be a contract between the Board and the Medical Staff or any individual members thereof.

Applications for, conditions of, and the duration of appointment to the Medical Staff or the granting of privileges shall not be deemed contractual in nature since the continuance of any such privileges at this Hospital is based solely upon a Practitioner's continued ability to justify the exercise of such privileges and does not obligate the Practitioner to practice at the Hospital.

The Board is obligated to use essential fairness in dealing with Medical Staff members and Allied Health Professionals and applicants for these positions, and may fulfill that obligation by following the procedure specified in these Bylaws or any other procedures, which are fair under the circumstances.

I.

DEFINITIONS

1.1 "Hospital" shall mean Hendricks Regional Health, Danville, Indiana, and other facilities owned by the Hospital and which operate under the Hospital's Indiana Hospital license."

1.2 "Board of Trustees" or "Board" shall mean the Board of Trustees of the Hospital.

1.3 "Chief Executive Officer "or" CEO" means the individual appointed and selected by the Board to act on its behalf in the overall administrative management of the Hospital.

1.4 "Medical Staff" shall mean the formal organization of all Physicians who are privileged to attend patients or to provide other diagnostic, therapeutic, teaching or research services in the Hospital.

1.4.1 "Non-staff Health Care Professionals" are licensed independent practitioners and allied health individuals allowed to order procedures and treatments and receive the results of the evaluations to the extent permitted by law who are not members of the Medical or Allied Health Staffs.

1.5 "Medical Executive Committee" or "MEC" means that group of Active members of the Medical Staff chosen to represent and coordinate all activities and policies of the Medical Staff and its subdivisions.

1.6 "Physician" means an individual holding a M.D. or D.O. degree and who has been issued an unlimited current license to practice medicine in the State of Indiana.

1.7 "Practitioner" means, unless otherwise expressly provided, any Physician applying for or exercising Clinical Privileges or providing other diagnostic, therapeutic, teaching or research services in the Hospital; or an Allied Health Professional applying for or exercising specific clinical responsibilities or providing other diagnostic, therapeutic, teaching or research services in the Hospital as outlined by the AHP Professional Policy and Credentialing Manual.

1.8 "Allied Health Professional" or "AHP" means a licensed health care professional other than a licensed Physician. Allied Health Professionals can be further subdivided into "Independent Allied Health Professionals" ("IAHP") and "Dependent Allied Health Professionals" ("DAHP"). Independent Allied Health Professionals have an unrestricted Indiana license to render clinical care in their specialty. Dependent Allied Health Professionals may or may not be licensed and function under the direct supervision of an appropriately licensed independent practitioner who has Privileges to provide care in the Hospital.

1.9 "Clinical Privileges" or "Privileges" means the rights granted to a Practitioner to provide those diagnostic, therapeutic, medical, surgical, dental or podiatric services specifically delineated to him.

1.9.1 "Access to Hospital Services" means access by non-staff health care professionals to Hospital diagnostic, therapeutic and teaching services that are permitted under Indiana law. Appropriate services will be provided to patients presenting with written orders by appropriately licensed Non-staff Health Care Professionals.

1.10 "Prerogative" means a participatory right granted, by virtue of Staff category or otherwise, to a Staff member or Allied Health Professional, and exercisable subject to the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

1.11 "Medical Staff Year" means the period from January 1 to December 31.

1.12 "Ex Officio" means services as an appointee of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

1.13 "Special Notice" means notification sent by certified or registered mail, return receipt requested, or by hand delivery or by courier service designed for overnight or same day delivery.

1.14 "Medico-Administrative Officer" means a Physician holding a formal administrative position with the institution while also maintaining clinical privileges.

1.15 "Oral Surgeon" means a licensed dentist with advanced training qualifying him for board certification by the American Board of Oral and Maxillofacial Surgery.

1.16 "Peer Review Committee" shall mean the Board , the MEC, Clinical Review Committee, Physician Relations Committee, and/or any other committee of the Medical Staff which recommends or takes actions based on the competence or professional conduct of an individual Practitioner and which affects or may affect the Clinical Privileges or membership on the Medical Staff of any Practitioner, including any recommendation or decision whether the Practitioner may have Clinical Privileges with respect to or membership in the Medical Staff of the Hospital, the scope or conditions of such Privileges or membership, or any changes or modifications in such privileges or membership.

1.17 “Patient contacts” are defined as admissions, consultations, procedures (inpatient and outpatient), and/or evaluations and services performed in the Emergency Department. This excludes patients evaluated or treated in the office setting, immediate care center, or occupational medicine department.

1.18 "Quorum" shall mean: Service Committees - presence of those present at the meeting. Physician Relations, Bylaws and Medical Executive Committee – presence of 40% of voting members. General Medical Staff meetings - presence of 40% of the Active Medical Staff.

II.

RESPONSIBILITY OF THE MEDICAL STAFF

2.1 RESPONSIBILITIES

To accomplish the above purposes, it is the obligation and responsibility of the organized Medical Staff.

2.1-1 To participate in the Hospital's quality assurance program by:

A. Evaluating Practitioner and institutional performance through sound measurement systems (ongoing monitoring based on valid criteria);

B. assisting in the evaluation of practitioners' credentials for initial and continuing Medical Staff appointment and for the delineation of Clinical Privileges in a manner that is thorough, effective and timely, and to provide mentoring to newly appointed members of the Medical Staff;

C. provide opportunities for continuing medical education based in part on needs demonstrated through quality review and evaluation programs; and

D. developing a sound system of resource management through participation in interdisciplinary clinical teams

2.1-2 To make recommendations to the Board through the MEC regarding appointments, reappointment to the Medical Staff, including Staff category, committee assignments and Clinical Privileges.

2.1-3 To participate in the Board's planning activities, to assist in identifying community health needs and to suggest to the Board appropriate institutional policies and programs to meet those needs.

2.1-4 To develop, administer, recommend amendments to and enforce compliance with these Bylaws, its supporting manuals and the Rules and Regulations of the Medical Staff, and with the Hospital Bylaws and policies.

2.1-5 To participate in the Hospital's Organized Health Care Arrangement (OHCA), as that OHCA is more described in the Hospital's Notice of Privacy Practice, and to abide by the terms of the **Joint** Notice of Privacy Practices with respect to patient information created or received by the Medical Staff as part of its participation in the OHCA. In compliance with HIPAA privacy rules that permit covered entities to share protected health information for treatment, payment and health care operations (TPO), the OCHA allows Practitioners who have no relationship with a patient to access protected health information for patients for (TPO) including quality assurance, utilization review and peer review – without a business associate agreement and with a single Notice of Privacy Practices.

III.

APPOINTMENTS

3.1 GENERAL QUALIFICATIONS

Every Practitioner who seeks or enjoys staff appointment or Clinical Privileges must continuously demonstrate the following qualifications:

3.1-1 LICENSURE

A valid, unlimited, and current Indiana medical or Allied Health Professional license or certification and, for Physicians and Oral Surgeons, a current State Controlled Substance Registration and Federal Drug Enforcement Agency Certificate are required for those providing direct care.

(Exception: Telemedicine practitioners that practice outside the State of Indiana and do not write prescriptions within the state do not require an Indiana Controlled Substance Registration. A valid, unrestricted Indiana Medical License and Federal DEA are required.)

3.1-2 EDUCATION

A. A Practitioner shall be a graduate of a medical school approved by the Liaison Committee on Medical Education, representing the American Medical Association, the Association of American Medical Colleges, and the World Health Organization, or a graduate of a school of osteopathic medicine having equivalent standards; or an oral maxillofacial surgeon who is a graduate of a dental school accredited by the Commission on Dental Accreditation of the American Dental Association and who has completed an accredited Oral and Maxillofacial Surgery training program; who can document background, experience, training and demonstrated competence; adherence to the ethics of his/ her profession; good reputation; ability to work with others; mental and health status, if requested, with sufficient adequacy to assure the Medical Staff and the Board that any patient treated by him/her will be given appropriate medical/dental care, consistent with community standards.

The Practitioner shall have the burden of producing adequate information for a proper evaluation of his/her experience, professional ethics, background,

training, demonstrated ability, and physical and mental status, and of resolving any doubts about these or any of the other basic qualifications specified herein above, as delineated on the application for Clinical Privileges. The Practitioner shall have the obligation to continuously update his/her file with the most current information available. Failure to provide accurate information or promptly update an application will result in administrative denial or, if the applicant is already appointed, automatic termination. In either instance, such action shall be administrative and not trigger fair hearing rights.

Failure to adequately complete the application form, the withholding of requested information, or the providing of false or misleading information, shall in and of itself, constitute a basis for denial or revocation of appointment.

The foregoing qualifications shall not be deemed exclusive of other qualifications and conditions deemed by the Hospital or Medical Staff to be relevant in considering a Practitioner's qualifications for Clinical Privileges in the Hospital.

B. Practitioners shall have their practice in the Hospital service area in order to provide continuous care to inpatients. Practitioners must visit each of his/her patients on a daily basis and must respond to patients needing attention at the Hospital within a medically reasonable period of time, twenty-four (24) hours a day, seven (7) days per week. A Practitioner may meet this obligation personally or by coverage by another Practitioner who has equivalent Privileges. This excludes Telemedicine practitioners providing diagnostic services via electronic means.

C. Practitioners must continuously demonstrate a willingness and capability based on current attitude and evidence of performance, to work with and relate to other Practitioners, residents, students, members of other health disciplines, Hospital management and administration, employees, visitors in the community in general, in a cooperative and professional manner that is essential for maintaining a Hospital environment appropriate to patient care.

Further, Practitioners must demonstrate documentation of training, experience and demonstrated competence and the ability and willingness to make efficient use of Hospital facilities so as not to jeopardize the financial stability of the institution and to further exhibit no impairment of physical, mental, and emotional health that could impact clinical judgment or patient care.

3.1-3 PERFORMANCE

The physician will provide evidence of professional education, post graduate training, and experience demonstrating current clinical competence.

3.1-4 ATTITUDE

A. Willingness and capability based on current attitude and documented performance to:

- discharge Medical Staff obligations appropriate to Staff category;
- adhere to the code of ethics/professional conduct prescribed by the American Medical Association (AMA) and/or American Osteopathic Association (AOA) and/or the American Association of Oral and Maxillofacial Surgeons (AAOMS) including, but not limited to, prohibitions against fee-splitting, "ghost" surgery, delegating the responsibility for diagnosis or care of patients to a Practitioner not qualified to undertake that responsibility, and failing to obtain informed patient consent for treatment. In addition, strictly comply with applicable state and federal laws, rules and regulations, including but not limited to confidentiality and privacy laws and regulations.

3.1-5 PROFESSIONAL LIABILITY INSURANCE

Provide evidence of professional liability insurance and the payment of the surcharge so as to qualify the Practitioner as a qualified provider under the Indiana Medical Malpractice Act and agree to continuously maintain such insurance and to pay the surcharge necessary so as to remain so qualified while appointed to the Medical Staff.

3.1-6 DISABILITY

Freedom from any significant physical or behavioral impairment that interferes with the qualifications required in Section 3.1-2, such that patient care is likely to be affected.

3.2 NON DISCRIMINATION

No aspect of Medical Staff appointment/privileges shall be denied on the basis of age, sex, race, creed, national origin, handicap or on the basis of any other criterion, which does not impact the Practitioners ability to discharge the Privileges for which he/she has applied or is unrelated to the delivery of quality patient care in this Hospital, to the professional qualifications, to the Hospital's purposes, needs and capabilities, or to the community needs.

3.3 BASIC RESPONSIBILITIES OF INDIVIDUAL STAFF APPOINTMENT

Each Practitioner exercising any Privileges shall:

A. provide patients with continuous care at the generally recognized professional level of quality and efficiency;

B. participate in their respective primary or secondary call schedule. The on-call Practitioner must respond when summoned by the emergency medicine physicians in the appropriate time frame. When a Practitioner reaches age 60 or older, he/she may request not to take hospital call. This request must be submitted in writing to the Medical Staff Office at least six (6) months in advance of the proposed effective date of the request. The Medical Staff office will forward the request to the Medical Executive Subcommittee on Call Coverage for consideration. Their recommendation will be forwarded to the Medical Executive Committee for approval. Notwithstanding any language in these Bylaws to the contrary, a Practitioner’s employment agreement shall take precedence over and govern his/her on call obligations.

C. abide by the Medical Staff Bylaws, Medical Staff Rules and Regulations, corporate compliance policies and all other lawful standards, policies, and rules of the Hospital;

D. discharge such Staff functions for which he/she is responsible by appointment, election or otherwise;

E. prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or in any way provides care to in the Hospital;

F. Communicate at all times in a professional manner, demonstrating mutual respect for patients and other healthcare providers and abstaining from abusive or intimidating language or actions.

G. Understand and willingly participate in programs to advance quality, patient safety, regulatory compliance, emergency preparedness, and/or risk avoidance of the Hospital.

H. For osteopathic Physicians: subscribe to and utilize the distinctive osteopathic approach in the provision of care.

I. Staff members shall immediately notify the Medical Staff Office if there is any change in their licensure status, state CSR or DEA registrations, board certification, eligibility for coverage under the Indiana Patients Compensation Act, Medicare or Medicaid status, right to participate in commercial payer programs, or staff membership or clinical privileges at another hospital or surgery center. Failure to provide such notice may result in administrative restriction, suspension, or termination of privileges without recourse to the fair hearing process.

3.4 TERM OF APPOINTMENT

A. Reappointment to any category of the Medical Staff will be for a period of not more than two (2) years. The procedures for appointment and reappointment of Practitioners are outlined in the Credentials Policy and Procedure Manual and are incorporated herein by reference.

3.5 PRACTITIONER PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

The provisions of the Credentials Policy and Procedure Manual shall govern the use of certain Hospital facilities by Staff members who have exclusive contractual arrangements with the Hospital.

The effect of expiration or termination of such an exclusive contract on the Practitioner's appointment status and clinical privileges shall be governed by the term of the contract and, where not in conflict, the provisions of the Credentials Policy and Procedure Manual.

3.6 MEDICO-ADMINISTRATIVE OFFICERS

A Medico-Administrative Officer must be a member of the Medical Staff, achieving this status by the procedure provided in Article IV.

His/her Clinical Privileges must be delineated in accordance with Article V. Provided that, notwithstanding any provision of these Bylaws or Medical Staff policy to the contrary, the Hospital CMO/CMIO, Senior VP Medical Affairs Administration shall be a member of the active Medical Staff by virtue of that office and need not maintain clinical privileges. If a Medico-Administrative Officer's contract provides that continuation of Privileges is contingent upon the maintenance and continuation of a contractual relationship, such Physician's Privileges shall immediately terminate pursuant to the terms of the contract and the Physician shall not be entitled to the Corrective Action/Fair Hearing procedure as provided in these Bylaws.

IV.

MEDICAL STAFF CATEGORIES AND ALLIED HEALTH PROFESSIONALS

4.1 CATEGORIES

There are two (2) categories within the Medical Staff: Active and Affiliate medical staff category. Credentialed Allied Health Professionals may be selected and participate in the Staff organization as provided for in the AHP Manual. Additionally, the MEC may recommend candidates who have made significant contributions to the Hospital or Hendricks County community for Emeritus status to the Board.

4.2 ACTIVE CATEGORY

4.2-1 QUALIFICATIONS

The Active Medical Staff shall consist of Physicians and Oral Surgeons who exceed the threshold for Affiliate Status due to their active practice at the Hospital. Members shall take an active role in Medical Staff activities, functions, and responsibilities, including, where appropriate, emergency service care, mentoring activities, call coverage, and

consultation assignments. Members of the Active Medical Staff shall be eligible to vote, to hold office and to serve on Medical Staff committees.

A. Physician groups, partnerships, associations, etc. where there is more than one physician practicing together who individually apply for Medical Staff membership shall be granted the usual and full responsibility and privileges if they meet the Active Medical Staff criteria. However, the eligible number of votes for the physician group, partnership, association, etc. shall be based on the number of full-time equivalent Physicians on the Active Medical Staff and/or local office per day. The attendance of physicians from a group, partnership, associate, etc. at a Medical Staff meeting shall be fulfilled by the number of physician votes granted. The MEC shall make the determination of votes upon initial application and/or reappointment.

4.2-2 PREROGATIVES OF ACTIVE CATEGORY

Appointees to this category may:

A. admit patients without limitation, except as otherwise provided in the Medical Staff Rules and Regulations;

B. vote on all matters presented at general and special meetings of the Medical Staff, and of committees to which he/she is appointed;

C. hold office and sit on or be the chairman of any committee, unless otherwise specified elsewhere in these Bylaws.

D. exercise such clinical privileges as are granted to him/her;

4.2-3 RESPONSIBILITIES OF ACTIVE CATEGORY

Appointees to this category shall:

A. contribute to the organizational and administrative affairs of the Medical Staff;

B. actively participate in recognized functions of Staff appointment including performance improvement, monitoring, peer review activities as may be assigned, and in discharging other Staff functions as may be required from time to time;

C. attend at least one-half (50%) regular General Medical Staff meetings and encourage active participation in service and committee meeting to which he/she has been appointed or equivalent assistance to the Medical Staff through alternative service opportunities such as clinical subcommittees, mentoring new Practitioners, providing community services for underserved populations, peer review consultations, and other activity approved by the Chief of Staff or Service Chair/designees in advance of the service;

D. faithfully perform the duties of any office or position to which elected or appointed;

E. pay all dues and assessments promptly as outlined in these Bylaws.

4.3 AFFILIATE STAFF CATEGORY

4.3-1 QUALIFICATIONS FOR AFFILIATE STAFF CATEGORY

The Affiliate Staff shall consist of those qualified Physicians who are actively involved in

twenty five (25) or fewer direct Hospital inpatient and/or outpatient care contacts or those office-based Physicians who satisfy such other criteria as the Medical Executive Committee may adopt from time to time.

4.3-2 PREROGATIVES OF THE AFFILIATE STAFF CATEGORY

Affiliate Staff members Staff members shall:

A. not serve as officers of the Medical Staff
B. attend Medical Staff meetings and vote
C. during times of shortage of available Hospital beds, the admission of Affiliate Staff may be subordinate to those of the Active Staff. .

4.3-3 RESPONSIBILITIES OF THE AFFILIATE STAFF CATEGORY

Affiliate Staff members shall:

A. provide evidence of clinical performance at their primary facility in such form as may be requested with each application for reappointment, including, but not limited to, information from the individuals' office practice, information from managed care organizations in which the applicant participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

B. must be actively involved in direct patient care either on an inpatient or outpatient basis and must meet credentialing/re-credentialing standards as outlined in the Medical Staff Credentialing Policy and Procedures Manual.

C. cooperate with the performance improvement, monitoring, and peer review activities at the Hospital, including responding fully and timely to any inquiries regarding the care of patients at the Hospital;

4.6 ALLIED HEALTH PROFESSIONALS (AHP)

4.6-1 GENERAL

A. Allied Health Professionals shall consist of those Practitioners who participate in Hospital inpatient and outpatient care. Certified Nurse Midwives, Nurse Practitioners, Certified Registered Nurse Anesthetists and Physician Assistants credentialed by and under supervision of members of the medical staff are included in this definition.

B. Allied Health Professionals shall be divided into two (2) categories; Independent and Dependent.

C. The activities of Allied Health Professionals will be governed by the Allied Health Professional Policy Manual.

V.

DELINEATION OF CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

A Practitioner may exercise only those Privileges granted to him/her by the Board or as specified in Section 5.6 of these Bylaws.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 Requests: Each application for appointment or reappointment to the Medical Staff must contain a request for specific Clinical Privileges desired by the application. Specific requests must also be submitted for temporary Privileges and for modification or privileges in the interim between reappraisals.

5.2-2 Basis for Privileges Determination: Requests for Clinical Privileges will be evaluated on the basis of education, training, experience and demonstrated competence, ability and judgment.

The basis for Privileges determination may include observed clinical performance and documented results of the Staff's quality assurance program activities, as in accordance with the Credential Policy and Procedure Manual. Privileges determinations will also be based on pertinent information from other sources, especially other institutions, and health care settings where a Practitioner exercises clinical privileges. The information will be added to and maintained in the Medical Staff file established for the Staff member.

5.2-3 System and Procedure for Delineating Privileges: The procedure by which requests for Clinical Privileges are processed and the specific qualifications for the exercise of Privileges are provided in the Credentials Policy and Procedure Manual and is incorporated herein by reference.

5.3 SPECIAL CONDITIONS FOR ORAL SURGEON, DENTAL AND PODIATRIC PRIVILEGES

Requests for Clinical Privileges for Oral Surgeons, Dentists and Podiatrists are processed in the manner specified in this Article. The scope and extent of the surgical procedures that each such practitioner may perform will be specifically delineated and granted in the same manner as all other surgical procedures. The Chief of Surgery will be responsible for evaluation and monitoring of surgical procedures performed by Oral Surgeons, Dentists and Podiatrists. All dental and podiatric patients will receive a basic medical appraisal history and physical by a Hendricks Credentialed Provider. A Physician will also be responsible for the care of any medical problem that may be present on admission or that may arise during Hospitalization. This Physician will have the responsibility for the total health status of the patient and any surgical procedure performed must be with his/her knowledge and concurrence.

5.4 TEMPORARY PRIVILEGES

5.4-1 CONDITIONS

Temporary privileges may be granted only in the circumstances described in Section 5.4-2, the procedures for granting temporary privileges are outlined in Article V of the Credentialing Policy and Procedures Manual and are incorporated herein for reference.

5.4-2 CIRCUMSTANCES

Upon written concurrence of the chief of the service where the Privileges will be exercised or the Chief of Staff, Chief Medical Officer or the Chief Executive Officer may grant temporary privileges in the following circumstances.

A. Care of Specific Patient – Temporary Privileges may be granted to a Practitioner who is not an applicant for Medical Staff appointment, for the care of specific patient/patients. These Privileges will be limited to no more than three patients in any twelve-month period. Privileges shall expire within thirty days unless written request for an additional thirty-day extension is received. This extension is granted only once, and Privileges expire at the end of the second thirty-day period.

B. Locum Tenens Privileges – Temporary Privileges may be granted to a Practitioner serving locum tenens for an appointee of the Medical Staff. These

Privileges are limited to the treatment of the patients of the Staff appointee from whom this Practitioner is serving locum tenens.

5.4-3 TERMINATION OF TEMPORARY PRIVILEGES

Any or all of a Practitioner's temporary Privileges may be terminated where the life or well-being of the patient is determined to be endangered. The mechanism for termination of temporary Privileges is outlined in the Credentialing Policy and Procedures Manual.

5.4-4 RIGHTS OF THE PRACTITIONER WITH TEMPORARY PRIVILEGES

A Practitioner is not entitled to the procedural rights afforded by the Bylaws and the Corrective Action/Fair Hearing Plan because his/her request for temporary Privileges is refused or because all or any part of his/her temporary Privileges are terminated or suspended.

5.5 EMERGENCY PRIVILEGES

5.5-1 Attendance of a Patient in an Emergency Situation

In the event of a patient emergency (a serious situation or occurrence that happens unexpectedly and demands immediate action), any Medical Staff appointee is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the appointee's license, but regardless of service affiliation, Staff category, or level of privileges. A Practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

5.5-2 Emergency Privileges in the Event of Disaster

Once an officially declared disaster has been confirmed and the appropriate Incident Commander (in accordance with the Emergency Operation and Disaster Plan) determines that additional medical personnel are required to provide services, he/she may request credentialing of additional IAHPs in needed specialty areas.

Privileges will be granted by the appropriate Incident Commander handling the disaster, upon recommendation by the appointed Medical Staff director or Chief Medical Officer. A Practitioner’s disaster Privileges will be immediately terminated in the event any information received through the verification process indicates any adverse information or suggests the person is not capable of rendering services in an emergency or if patient safety concerns are identified.

When the emergency situation no longer exists, emergently granted privileges terminate. Practitioners will be duly informed by the Incident Commander or designee when services are no longer required.

Refer to Credentialing Physicians In the Event of Disaster Policy for process by which privileges are granted during a declared disaster situation.

VI.

OFFICERS

6.1 GENERAL OFFICERS OF THE STAFF

6.1-1 IDENTIFICATION

The general officers of the staff shall be:

A. Chief of Staff

B. Vice Chief of Staff

C. Secretary/Treasurer

6.1-2 OTHER OFFICIALS OF THE STAFF

Other officials of the Staff may include a Chief Medical Officer, service chiefs, a director of medical education, utilization review chair, osteopathic methods chair (when applicable), and such other officials as may be selected pursuant to these Bylaws. To the extent that any such official performs any clinical function, he/she must become and remain a member of the Active Staff. In all events, he/she is subject to these Bylaws, the Rules and Regulations and all other policies of the Hospital.

6.1-3 QUALIFICATIONS

General officers must be members of the Active category at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

The Chief of Staff and Vice Chief of Staff must be Physician with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of training, experience, and ability to direct the medico-administrative aspects of Hospital and the Medical Staff activities.

Members of the MEC will be exposed to sensitive information including, but not limited to, Peer Review, Quality Assessment and Improvement, Strategic Planning, and Operational Issues. In all dealings with and on behalf of the Hospital or any affiliated entity, MEC members shall be held to strict rules of honest and fair dealing, and no such MEC member shall use his/her position or knowledge gained in such a manner to create a conflict or appearance of a conflict between the interest of the Hospital or any affiliated entity and the interest of the MEC member.

Any violation related to conflict of interest would be considered a serious offense and could subject the Medical Staff leader to corrective action under the Bylaws. Depending upon the seriousness of violation, such corrective action could include corrective actions ranging from a letter of admonition, up to and including a recommendation to the Board for suspension or termination of Staff membership and privileges.

6.1-4 NOMINATIONS

A. By Nominating Committee: The nominating committee shall consist of three Medical Staff members, with at least one who would have been a Chief of Staff. appointed by the present Chief of Staff and shall submit to the Staff's Secretary one or more qualified nominees for each office. The names of such nominees shall be reported to the Staff at least thirty (30) days prior to the annual meeting.

B. By Petition: Nominations may also be made by petition signed by at least fifteen (15) percent of the members of the Active category and filed with the Secretary at least fifteen (15) days prior to the annual meeting. As soon thereafter as reasonably possible, the names of these additional nominees shall be reported to the Staff.

C. By Other Means: If, before the election, any of the individuals nominated for an office pursuant to Section 6.1-4 A and B shall refuse, be disqualified from, or otherwise be unable to accept nominations, then the nominating committee shall submit one or more substitute nominees at the annual meeting.

6.1-5 ELECTION

Officers shall be elected at the annual meeting of the Staff. A nominee shall be selected upon receiving over fifty (50%) percent of the valid votes cast at a meeting at which a quorum of the Staff is present and voting. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. If no contest, voting may occur by a show of hands.

6.1-6 TERM OF ELECTED OFFICE

Each officer shall serve a two-year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of their term or until a successor is elected, unless he/she shall sooner resign or be removed from office. The maximum number of consecutive terms is limited to two (2) for the Chief of Staff. Term limits for other MEC members shall be determined by the ability of officials to efficiently and effectively provide leadership and maintain the confidence of the Medical Staff.

6.1-7 REMOVAL OF GENERAL STAFF OFFICER

Except as otherwise provided, removal of a Staff officer may be initiated by a 66% vote of the members of the Staff eligible to vote. Removal may be based only upon failure to perform the duties of the position held as described in these Bylaws, or due to violation of ethics or for other appropriate reasons. If an officer is deemed a medico-administrative officer, their removal shall be accomplished pursuant to Article 3.6.

6.1-8 VACANCIES IN ELECTED OFFICE

Vacancies in offices shall be filled by the MEC. If there is a vacancy in the Office of Chief of Staff, the Vice Chief of Staff shall serve out the remaining term. A vacancy in the office of Vice Chief of Staff shall be filled by a special election conducted as reasonably soon after the vacancy occurs as possible following the general mechanism outlined in Section 6.1-4 and 6.1-5.

6.2 DUTIES OF GENERAL OFFICERS

6.2-1 CHIEF OF STAFF

The Chief of Staff serves as the chief officer of the Medical Staff. As the principal elected official of the Staff, the Chief of Staff shall:

A. Aid in coordinating the activities and concerns of the Hospital administration and of the nursing and other patient care services with those of the Medical Staff.

B. Communicate and represent the opinion, policies, concerns, needs and grievances of the Medical Staff to the Board, the Chief Executive Officer, Chief Medical Officer and other officials of the Staff.

C. Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, and Credential Policy and Procedure Manual, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner.

D. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.

E. Serve as chairman of the MEC, as an ex officio member of the Joint Conference Committee (if such exists) and as an ex-officio member without vote on all other Staff committees.

6.2-2 VICE CHIEF OF STAFF

The Vice Chief of Staff (or his/her designee) shall be responsible for the Bylaws review/revision function. He/she shall be a member of the Medical Executive Committee and a Medical Staff representative to the Joint Conference Committee (if such exists). In the absence -- temporary or permanent -- of the Chief of Staff, he/she shall assume all the duties and have the authority of the Chief of Staff. He/she shall perform such additional duties as may be assigned by the Chief of Staff, or the Medical Executive Committee.

6.2-3 SECRETARY-TREASURER

The Secretary-Treasurer shall be a member of the Medical Executive Committee whose duties shall be to:

A. assure that proper notice of all Staff meetings is given;

B. assure that accurate and complete minutes for all Staff meetings are prepared;

C. supervise the collection and accounting for any funds that may be collected in the form of Staff dues, assessments, or other fees; and

D. perform such other duties as ordinarily pertain to this office.

6.3 OTHER OFFICIALS OF THE STAFF

6.3-1 SERVICE CHIEFS

A. Qualifications: Each service chief shall be a member of the Active category, shall be willing and able to discharge the functions of their office.

B. Selection and Appointment: The service chief shall be elected by the Medical Staff and is a member of the MEC.

C. Term of Office: A service chief shall serve a two-year term commencing with the Medical Staff year. A service chief may be removed from office by either of the following two methods:

1. By action of the Medical Executive Committee which action is thereafter sustained by a two-thirds vote of the Active Staff members present at a Medical Staff meeting at which a quorum is present and voting.

2. By a two-thirds vote of the Active Staff members of the Medical Staff present at a Staff meeting at which a quorum of the Medical Staff Active members is present and voting. If the Service Chief is deemed a medico-administrative officer, his/her removal shall be accomplished pursuant to Article 3.6.

D. Duties: Each service chief shall:

1. Be accountable to the MEC and the Chief of Staff for all professional activities within their service, and particularly for the quality of patient care rendered by members of the service and for the effective conduct of the patient care evaluation and monitoring functions delegated to his/her service.

2. Submit written reports to the Medical Executive Committee on a regularly scheduled basis concerning: (1) findings of the service's review, evaluation and monitoring activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the service and the Hospital; and (3) such other matters as may be required from time to time by the MEC. The service chief shall participate in review of trended data as a member of the Quality Forum, or shall delegate that responsibility to another committee member.

3. Develop and implement departmental programs in cooperation with the Chief of Staff and consistent with the provisions of Article VII, for retrospective patient care audit, on-going monitoring of practice, credentials review and privileges delineation, medical education, medical necessity and utilization review.

4. Be a member of the MEC, give guidance on the medical policies of the Hospital, and make specific recommendations and suggestions regarding his/her service.

5. Maintain continuing review of the professional performance of all Practitioners with Clinical Privileges and of all AHPs with specified services in their service and report regularly thereon to the Chief of Staff and to the Medical Executive Committee.

6. Transmit to the appropriate authorities as required by these Bylaws, his/her recommendations concerning appointment and classification, reappointment, delineation of Clinical Privileges or specified services, and corrective action with respect to Practitioners in his/her service.

7. Appoint such committees as are necessary to conduct the functions of the service as specified in Article VII and designate chairman.

8. Enforce the Hospital and Medical Staff Bylaws, Rules, Regulations and Policies, including initiating corrective action and investigation of clinical performance and ordering consultations to be provided or to be sought when necessary.

9. implement actions taken by the Medical Executive Committee and by the Board.

10. participate in the administration of the service through cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques.

11. assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her service as may be required by the Medical Executive Committee, the Chief Executive Office or the Board.

12. appoint a vice chief with the concurrence of the Medical Executive Committee.

13. perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by the Chief of Staff or the Medical Executive Committee.

VII.

STAFF CLINICAL SERVICES

7.1 ORGANIZATION OF SERVICES

Each service shall be organized as a separate part of the Medical Staff and shall have a chief who is selected and has the authority, duties and responsibilities as specified in Article VI.

7.2 DESIGNATION

7.2-1 CURRENT SERVICES

An up-to-date list of services and sections of the Medical Staff will be kept in the Medical Staff Office, and a current copy of such list shall be attached to these Bylaws and incorporated by reference.

7.2-2 FUTURE SERVICES

When deemed appropriate and consistent with the provisions of Section 7.5, the Medical Executive Committee, the Board and the Chief Executive Officer, by their joint action, may create a new, eliminate, subdivide, further sub-divide or combine services.

7.3 ASSIGNMENT TO SERVICES

Each Member of the Staff and each AHP may be assigned to one service but may be granted Clinical Privileges or specified services in one or more of the other services. The exercise of Clinical Privileges or the performance of specified services within any service shall be subject to the Rules and Regulations of that service and the authority of the service chief.

7.4 FUNCTIONS OF SERVICES

The primary responsibility delegated to each service is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in that service.

To carry out this responsibility, each service shall:

7.4-1 conduct special studies of care and specified monitoring activities, including mortality and surgical case review, for the purpose of evaluating clinical work performed under its jurisdiction.

7.4-2 establish guidelines for the granting of Clinical Privileges and the performance of specified services within the service and submit the recommendations required under Articles III and V regarding the specific privileges each Staff member or Practitioner may exercise and the specified services each AHP may provide.

7.4-3 conduct or participate in and make recommendations regarding the need for continuing education programs pertinent to change in the state-of-the-art and to findings of review, evaluation, and monitoring activities.

7.4-4 monitor, on a continuing and concurrent basis, adherence to: (1) Staff and Hospital policies and procedures; (2) requirements for alternate coverage and for consultations; and (3) sound principles of clinical practice.

7.4-5 coordinate the patient care provided by the services' members with nursing and

ancillary patient care services and with administrative support services.

7.4-6 meet on regular basis for the purpose of receiving, reviewing, and considering patient care review findings and the results of the services other review, evaluation and monitoring activities and of performing or receiving reports on other services and Staff functions.

7.4-7 establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

7.5 MODIFICATIONS IN CLINICAL ORGANIZATION UNIT

In creating, eliminating, subdividing, or combining service, section or any other clinical organization unit that may exist or be contemplated, the following guidelines shall be followed:

7.5-1 Creation or Subdivision: A sufficient number of Practitioners are available for appointment to and will be appointed to and/or actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these Bylaws, the Rules and Regulations, and the patient or service activity to be associated with the new component is substantial enough to warrant imposition of the responsibility to accomplish those functions.

7.5-2 Eliminations: The number of Practitioners is no longer adequate and will not be so in the foreseeable future to accomplish assigned functions, or the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant imposition of the responsibility to accomplish those assigned functions or failure to meet as required by these Bylaws.

7.5-3 Combinations: The union of two or more organizational components will result in more effective and efficient accomplishment of assigned functions, and the patient or service activity to be associated with the combination is substantial enough, without being unwieldy, to warrant imposition of the responsibility to accomplish those assigned functions.

In all instances of modification, the Hospital's written plan of development as currently being implemented and any constraints or mandates imposed by external planning authorities shall also be considered.

VIII.

COMMITTEES AND FUNCTIONS

8.1 DESIGNATION AND SUBSTITUTION

There shall be a Medical Executive Committee and such other standing and special committees of the staff responsible to the MEC as may from time to time be necessary and desirable to perform the Staff functions listed in these Bylaws. The MEC may, by resolution and upon approval by the Board, establish a committee to perform one or more of the required functions. Those functions requiring participation of, rather than direct oversight by, the Staff may be discharged by the Medical Staff representation on such Hospital committees as are established to perform such functions. Whenever these Bylaws required that a function be performed by, or that a report or recommendation be submitted to:

8.1-1 A named Medical Staff committee but no such committee shall exist, the MEC shall perform such function or receive such report or recommendation or shall assign the functions to a new or existing committee of the Staff or to the Staff as a whole.

8.1-2 The MEC, but if a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

8.2 MEDICAL EXECUTIVE COMMITTEE

8.2-1 COMPOSITION

The Medical Executive Committee shall consist of the Chief of Staff, the Vice Chief of Staff, Secretary-Treasurer of the Medical Staff, Chief Medical Officer Chairs of the following Committees(Ancillary P&T, Emergency/Urgent Care, Clinical Review, Outpatient Clinical Review, Physician Relations, Medicine/ICU; Surgery; Provider Advisory) such other persons as the Chief of Staff may invite in his/her discretion. The Chief Executive Officer and/or designee shall be an ex officio member without vote. The Chief of Staff shall serve as chairman of the committee. The immediate past Chief of Staff will become an ex-officio, non-voting member of the Medical Executive Committee for the term of the existing Chief of Staff.

8.2-2 DUTIES

The duties of the MEC shall be to:

A. Receive or act upon reports and recommendations from the committees and officers of the staff concerning patient care quality and appropriateness reviews, evaluation and monitoring functions and the discharge of their delegated administrative responsibilities and recommend to the Board specific programs and systems to implement these functions.

B. Coordinate the activities of any policies adopted by the Staff and committees.

C. Recommend to the Board all matters relating to appointments, reappointments, Staff category, committee assignments, clinical privileges and corrective action.

D. Account to the Board and to the Staff for the overall quality and efficiency of patient care in the Hospital.

E. Provide continuing education opportunities responsive to quality activity findings, new state-of-the-art developments and other perceived educational needs.

F Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of Staff members including initiating investigations and initiating and pursuing corrective action, when warranted.

G. Make recommendations on medico-administrative and Hospital management matters.

H. Inform the Medical Staff on the accreditation program and the accreditation status of the Hospital.

I. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.

J. Represent and act on behalf of the Staff, subject to such limitations as may be imposed by these Bylaws.

K. Propose Medical Staff Rules and Regulations for approval by the Medical Staff and the Board.

8.2-3 MEETINGS

The MEC shall meet at least monthly or for more urgent needs at the request of the Board or Hospital administration. A permanent record of MEC meeting proceedings and actions shall be maintained.

8.3 STAFF FUNCTIONS

Provisions shall be made in these Bylaws or by resolution of the MEC approved by the Board, either through assignment to the services, to Staff committees, to Staff officer or officials or to interdisciplinary Hospital committees, for the effective performance of the Staff functions specified in this Section 8.3 and of such other Staff functions as the Medical Executive Committee or the Board shall reasonably require:

8.3-1 Monitor and evaluate care provided in and develop clinical policy for; special care areas, such as intensive or coronary care units; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, outpatient, and other ambulatory care services.

8.3-2 Conduct, coordinate and review patient care reviews of quality and appropriateness and monitoring activities, including tissue, blood usage, antibiotic and drug usage reviews, medical record, and surgical case reviews.

8.3-3 Conduct, coordinate, and review utilization review activities.

8.3-4 Conduct, coordinate and review credentials investigations and recommendations regarding staff membership and grants of clinical privileges and specified services.

8.3-5 Develop and maintain surveillance over drug utilization policies and practices.

8.3-6 Prevent, investigate, and control nosocomial infections and monitor the Hospital's infection control program, including community acquired and healthcare acquired infections in patients and health care workers

8.3-7 Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community.

8.3-8 Direct staff organizational activities, including staff Bylaws, review and revision, staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation.

8.3-9 Coordinate the care provided by Practitioners with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services.

8.4 PARTICIPATION ON INTERDISCIPLINARY HOSPITAL COMMITTEES

Staff functions and responsibilities relating to liaison with the Board and Hospital administration, Hospital accreditation, disaster planning, facility and services planning and financial management shall be discharged by the appointment of Medical Staff members to such Hospital functions by the Chief of Staff.

8.5 COMMITTEES OF THE STAFF

8.5-1 COMPOSITION AND APPOINTMENT

The committees of the staff are as followings: Ancillary P&T, Surgery, Medicine/ICU, Clinical Review, Outpatient Clinical Review, OB/Peds, Utilization Review, Physicians Relations, Emergency Medicine/ICU, Advanced Practice Provider Council, and Provider Advisory Committee.

A Staff committee established to perform one or more of the Staff functions required by these Bylaws shall be composed of members of the active and affiliate categories and may include, where appropriate, Allied Health Professionals and representation from Hospital administration, nursing services, medical records service, pharmaceutical service, social services, and such other services as are appropriate to the function(s) to be discharged.

Unless otherwise specifically provided, the Medical Staff members shall be appointed in the following manner. The Chief of Staff and committee chairman will jointly select and appoint the individual members of the committee. The MEC will retain the right of final approval for membership of service committees. Medical Staff committees established under this Bylaws' provision shall be composed of at least three (3) Physicians. The Chief of Staff, the Chief Executive Officer or their respective designees shall serve as an ex officio member without vote on all committees, unless otherwise expressly provided.

8.5-2 TERMS AND PRIOR REMOVAL

Unless otherwise specifically provided a Medical Staff committee member (other than one serving ex officio) shall continue as such for one year or until his/her successor is elected or appointed, unless he/she shall sooner resign or be removed from the committee. A Medical Staff committee member, other than one serving ex officio, may be removed by a majority vote of the MEC. An administrative staff committee member shall serve for a term equivalent to that of a Medical Staff committee member and until his/her successor is elected or appointed, unless he/she shall sooner resign or be removed from the committee. An administrative staff committee member may be removed by action of the Chief Executive Officer.

8.5-3 VACANCIES

Unless otherwise specifically provided, vacancies on any Staff committee shall be filled in the same manner in which original appointment to such committee is made.

8.5-4 MEETINGS

A Staff committee established to perform one or more of the functions required by these Bylaws shall meet as often as is necessary to discharge its assigned duties as prescribed in the Medical Staff Rules and Regulations.

IX.

PEER REVIEW/CORRECTIVE ACTION/FAIR HEARING PROCEDURAL RIGHTS

9.1 Procedural Rights

The Peer Review Policy and Corrective Action/Fair Hearing Plan as adopted by the Medical Staff and Board should be referenced for procedures under this Article and such procedures are incorporated herein by reference. Changes to these policies shall occur only after a 2/3 affirmative vote of the Active medical staff and upon approval of the Board of Trustees.

Any adverse action, with the exception of those actions under the Health Care Quality Improvement Act which require a report to be made to the Data Bank prior to the exhaustion of any hearing/appeal process (e.g., summary suspension for longer than thirty days, resignation of membership or privileges while under investigation, etc.), shall not be reported to the Data Bank until all procedures and appeals in these Medical Staff Bylaws have been completed or waived and there has been final action taken by the Board.

X.

MEETINGS

10.1 MEDICAL STAFF YEAR

The Medical Staff year will begin on January 1.

10.2 MEDICAL STAFF MEETINGS

10.2-1 REGULAR MEETINGS

Quarterly Medical Staff meetings will be held. The MEC may authorize the holding of additional general meetings by resolution. The resolution authorizing such additional meeting shall require notice specifying the place, date, and time for the meeting, and that the meeting can transact any business as may come before it.

10.2-2 SPECIAL MEETINGS

A special meeting of the Medical Staff may be called by the Chief of Staff, and must be called by the Chief of Staff at the written request of the Board, the MEC or by at least fifteen percent (15%) of the members of the Active Medical Staff.

10.3 COMMITTEE MEETINGS

10.3-1 REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution is required. The frequency of committee meeting is as required by these Bylaws or as prescribed by the Medical Staff Rules and Regulations more frequently as the Committee may deem necessary.

10.3-2 SPECIAL MEETINGS

A special meeting of any committee may be called by the chief thereof, and must be called by the chief at the written request of the Board, the Chief of Staff, or at least fifty percent (50%) of the group's current members who are members of the Active Medical Staff but not less than two (2) Physician members.

10.4 ATTENDANCE REQUIREMENTS

10.4-1 GENERAL

Each member of the Active Medical Staff must attend at least 50% of the general Medical Staff meetings and encouraged to actively participate in the committees to which they are assigned; unless excused by reason of continuing medical education outside the city, personal illness/crisis, or attending a critically ill patient. In the event the General Medical Staff Meeting is scheduled off site, Practitioners who are scheduled to be immediately available at the main campus; i.e. radiologists, Hospitalists, emergency medicine physicians should notify the Medical Staff Office. An absence must be reported to the Medical Staff Coordinator within one week following the missed meeting for an excused absence.

10.5 MEETING PROCEDURES

10.5-1 ORDER OF BUSINESS AND AGENDA AT GENERAL STAFF MEETINGS

The order of business at a regular meeting shall be determined by the Chief of Staff. The agenda shall include at least:

A. Reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting.

B. Performance Improvement Reports.

C. Administrative reports from the Chief Executive Officer, the Chief of Staff, and committees.

D. The election of officers and of representatives to Staff and Hospital committees, when required by these Bylaws.

E. Reports by responsible officers and committees on the overall results of reviews of patient care quality and appropriateness and other quality reviews, evaluation and monitoring activities of the Staff and on the fulfillment of the other required Staff functions.

10.5-2 NOTICE OF MEETINGS

Notice stating the place, day and hour of any general Staff meeting, of any special meeting, or of any regular committee meeting cancelled pursuant to resolution shall be delivered personally by telephone, fax, or email or by mail to each person entitled to be present thereat not less than (5) business days when possible nor more than ten business days from the date of such meeting. Notification of meetings that involve peer review will be carried out in accordance with the guidelines established in the Medical Staff Peer Review Policy and the Corrective Action Fair Hearing Plan.

Notice of committee meetings may be given verbally and/or by electronic communication. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

10.5-3 MINUTES

Minutes of all meetings, except peer review proceedings, shall be prepared by the secretary (or his/her designee) of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the members, forwarded to the Medial Executive Committee, and made available to the Staff. A permanent file of the minutes of each meeting shall be maintained.

10.5-4 MANNER OF ACTION

Except as otherwise provided, 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. Administrative action may be taken without a meeting by a committee by a written statement setting forth the action so taken signed by each member entitled to vote thereat, by telephone poll of committee members, or by electronic means such as email and fax. Action taken outside Committee will be documented in the Committee minutes.

XI.

CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1 SPECIAL DEFINITIONS

For purposes of this Article, the following definitions shall apply:

11.1-1 INFORMATION means a record of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, actions, data, and other disclosures or communications whatever in written or oral for relating to any subject matter specified in Section 12.3

11.1-2 MALICE means the dissemination of a known falsehood or of information with a reckless disregard for its validity.

11.1-3 THIRD PARTIES means both individuals and organizations providing information and representatives.

11.2 AUTHORIZATIONS AND CONDITIONS

By submitting an application for Staff appointments or by applying for or exercising Clinical Privileges or providing specified patient care services in this Hospital, a Practitioner:

11.2-1 authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing on his/her professional ability and qualifications;

11.2-2 agrees to be bound by the provisions of this Article and to waive all legal claim against any representative who acts in accordance with the provisions of the Article and these Bylaws.

11.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner submitted, collected or prepared by any representatives of this or any other health care facility, or organization, or Medical Staff for the purposes of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contribution to teaching or clinical research and determining that health care services are professionally indicated and performed in compliance with the applicable standards of care shall, to the fullest extent permitted by law, be confidential and shall not be used in any way except as provided herein or except as otherwise provided by law. Such confidentiality shall also extend to information of the kind that may be provided by third parties. This information shall not become a part of any particular patient's record.

11.4 IMMUNITY FROM LIABILITY

11.4-1 FOR ACTION TAKEN

A. No representative of the Hospital or Medical Staff shall be liable for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of their duties as a Representative, if they act in good faith and without malice after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.

B. Application for an/or acceptance of privileges (including reappointments) for a Practitioner practicing in the Hospital shall constitute an agreement to authorize the Medical Staff, any of its committees, members and/or agents of the Board, and any other personnel of any Peer Review Committee to inquire and to gather any and all information concerning the applicant or reapplicant. The Practitioner must provide such documentation to be sufficient to assure the Medical Staff and the Board that any patient treated by the Practitioner in the Hospital will be given an appropriate level of medical care. Such application shall further constitute an authorization to any and all persons and organizations to release such information to the Board, its agents, Personnel of Peer Review Committees, and/or employees. Such application shall constitute an agreement to release and hold harmless all persons, organizations (including the Hospital), the Board, its agents, Personnel of Peer Review Committees and employees, and all others who participate in good faith in providing or receiving information regarding the applicant and/or Staff member.

11.4-2 FOR PROVIDING INFORMATION

No Representative and no third party shall be liable to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff or to an appropriate state regulatory agency, concerning a Practitioner who is or has been an applicant to or a member of the Staff or who did or does exercise Clinical Privileges or provide specific patient care services at this Hospital, provided that such Representative acts in good faith and without malice and provided further than such information is related to the performance of duties and reported in a factual manner.

11.5 ACTIVITIES AND INFORMATION COVERED

11.5-1 ACTIVITIES

The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning but not limited to:

A. applications for appointment, Clinical Privileges or specified services;
B. periodic reappraisals for reappointment, Clinical Privileges or specified services;
C. corrective or disciplinary action;
D. hearings and appellate reviews;
E. performance improvement program activities;
F. utilization and claims reviews;
G. profiles and profile analysis;
H. malpractice loss prevention;
I. other Hospital and Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

11.5-2 INFORMATION

The information referred to in this Article may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics or any other matter that might directly or indirectly affect patient care.

11.6 RELEASES

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

XII.

GENERAL PROVISIONS

12.1 STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Medical Staff will adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws. The procedures outlined in Article XIII will be followed in the adoption and amendment of the Rules and Regulations except that Staff action may occur at any regular meeting of the Medical Staff in which a quorum is present and without previous notice, or any special meeting on notice, by a majority vote of those present who are eligible and qualified to vote.

12.2 SERVICE POLICIES

Subject to the approval of the MEC, each service may formulate its own Rules and Regulations for the conduct of its affairs and discharge of responsibility. Such Rules and Regulations shall not be inconsistent with these Bylaws, the general Rules and Regulations and manuals of the Medical Staff or other policies of the Hospital.

12.3 STAFF DUES

The Medical Staff through the Medical Executive Committee will establish the annual dues and assessments, as it deems appropriate. The Medical Executive Committee will review staff dues and assessments on an annual basis. Dues are payable upon initial appointment and annually thereafter. Failure, unless excused by the MEC for good cause, to render payment within three months of the start of the Medical Staff year shall, after special notice of the delinquency, result in a voluntary resignation of staff appointment, including all prerogatives and clinical privileges.

12.4 SPECIAL ASSESSMENTS

If funds of the Medical Staff are insufficient for any expenditure authorized by the MEC additional funds may be obtained through a special assessment of the Medical Staff. Prior to any such assessment, there must be a special meeting of the Medical Staff, called by the MEC for that purpose.

At this meeting, there must be a quorum present and a two-thirds affirmative vote is necessary for approval of the assessment. Voting members in any election concerning assessment will include all staff categories that the proposed assessment might affect. Written proxies will be accepted.

XIII.

ADOPTION AND AMENDMENT

13.1 PROCEDURE

Upon the request of the Chief of Staff, the MEC, the Bylaws Committee, the Board, or upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of some or all of these Bylaws. Such action shall be taken at a regular or special meeting provided:

(A) Written notice of the proposed changes were sent to all voting members at least 30 days before the next regular or special meeting of the Medical Staff, and

(B) Agenda of the next regular or special meeting includes notice that Bylaws changes would be considered following opportunity for discussion. Both notices shall include the exact wording of the existing Bylaw language, if any, and the proposed change(s).

13.2 ACTION ON BYLAWS CHANGE

If a quorum is present for the purpose of enacting a Bylaws change, the change shall require an affirmative vote of 2/3 of the members voting in person, or by written ballot.

13.3 APPROVAL

Bylaws changes adopted by the Medical Staff shall become effective following approval by the Board which approval or disapproval shall not be withheld unreasonably. Within 60 days after the first meeting of the Board when the change is presented, if no action is taken, then the amendment shall be approved automatically.

Bylaws changes requested by the Board of Trustees shall be approved or rejected by the Medical Staff within 60 days after written notice of the proposed change is sent to the Medical Staff. If no action is taken, the Board may approve the amendment at their next regular meeting.

13.4 EXCLUSIVITY

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

These signatures signify approval of the Bylaws as well as approval of related manuals and protocols developed to implement various sections of these Bylaws, i.e., Medical Staff Rules and Regulations, Special Care Rules and Regulations, Credentials Policy and Procedure Manual, and Corrective Action/Fair Hearing Plan.

ADOPTED by the Medical Staff on August 30, 2022

APPROVED BY:

The Board of Trustees of the Hendricks Regional Health on September 26, 2022

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