

PARKVIEW LAGRANGE HOSPITAL

LaGrange, Indiana

MEDICAL STAFF BYLAWS

APPROVED IN ENTIRETY

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PREAMBLE

These Bylaws, which originate with the Medical Staff, define the organizational structure of the Medical Staff at Parkview LaGrange Hospital. They provide a framework for self-governance in order to permit the Medical Staff to discharge its responsibilities in the delivery of quality medical care. They provide the professional and legal structure for Medical Staff operations, as well as the relationship of the organized Medical Staff with the Hospital Board of Directors. These Bylaws, when approved by the Hospital Board of Directors, create a system of mutual rights and responsibilities between members of the Medical Staff and Parkview LaGrange Hospital.

DEFINITIONS

“Active staff” or **“Active Medical Staff”** means those Medical Staff Members who routinely utilize the Hospital services, exercise those privileges granted by the Board of Directors to provide care for their patients, and assume all the duties and responsibilities of appointment on the Active Medical staff including but not limited to service on committees and attendance at Medical Staff meetings.

“Adverse Recommendation” means any recommendation on the part of the Medical Executive Committee or the Hospital Board of Directors to restrict, revoke, or deny privileges either requested by or previously granted to a Practitioner, or to deny Medical Staff appointment. These terms do not apply when the Practitioner is deemed ineligible for appointment or for the privilege or privileges requested based on Medical Staff Criteria. An Adverse Recommendation shall entitle the affected Practitioner to the hearing and appeal process as provided in these Bylaws.

“Affiliate Medical Staff” means those Medical Staff members who are otherwise qualified, but do not utilize the Hospital as their primary facility for medical practice. Unless otherwise stated, “Affiliate Medical Staff” members must maintain Active Staff Privileges at another facility that requires participation in quality management activities consistent with those of Parkview LaGrange Hospital.

“Allied Health Practitioners” means individuals who are not otherwise eligible for membership on the Medical Staff, but who, by documented experience and/or training, applicable licensure or certification, and demonstrated competence, are qualified to provide services needed or desired by the Hospital and the Medical Staff. Allied Health Practitioners may be either Dependent (e.g. RNs), Mid-level (e.g. NPs or PAs), or Independent (e.g. Optometrists). For individuals performing service as Allied Health Practitioners the Medical Executive Committee must approve their scope of practice (for Dependent AHP’s) or recommend them for Clinical Privileges to the Hospital Board of Directors (for Mid-level or Independent AHP’s).

“Appellate Review Body” means those Directors appointed by the Chair of the Hospital Board of Directors to review the appeal of an Adverse Recommendation made by the Medical Executive Committee vs. a Medical Staff Member after an evidentiary hearing has been completed.

“Clinical Advisors” means those Medical Staff Members appointed by the Chair of the Medical Executive Committee to oversee the clinical activities in a specific patient care area. Clinical Advisors shall make recommendations to the appropriate Medical Staff Committees regarding performance improvement activities, requests for Clinical Privileges, changes in policies and procedures, and any other issues that may arise all leading to continuous improvement in patient care.

“Contract physicians” means those Medical Staff members who provide services as contracted with the Hospital including Pathology, Radiology, Anesthesia, Hospitalist and Emergency Room physician coverage. Contract physicians may be Active or Affiliate Medical Staff members.

“Ex officio” means by virtue of an office or position held. Unless otherwise expressly provided, an ex officio committee member shall have full voting rights.

“Hearing Committee” means the committee appointed by the Hospital President in consultation with the President of the Medical Staff to review and make judgment regarding any Adverse Recommendation that has been proposed vs. any Practitioner with regard to their application to the Medical Staff and/or their Clinical Privileges.

“Hospital” means Parkview LaGrange Hospital.

“Hospital Board” or **“Hospital Board of Directors”** means the legally constituted governing body of Parkview LaGrange Hospital.

“Inquiry Body” means the committee appointed by the Medical Staff Officers to investigate a request for peer review action vs. a Practitioner.

“Medical Executive Committee” means the committee with voting members consisting of the entire Active Medical Staff. This committee serves as the governing body of the Medical Staff as described in these Bylaws (with the exception of duties specifically assigned to the four (4) Medical Staff Officers as described in ARTICLE V, at which time the Officers shall act with the full authority of the Medical Executive Committee).

“Medical Record” means the documentation of a patient’s care that serves as a communication tool for clinical information, support for financial claims, legal evidence, resource for research and statistical quality review, and an educational tool for clinicians.

“Medical Staff” means collectively those licensed practitioners holding Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, or Doctor of Podiatric Medicine degrees, which have been granted staff appointment by the Board of Directors of the Hospital.

“Peer Review Committee” means any committee of the governing body, Hospital, or Medical Staff that conducts professional review activity.

“Personnel of a Peer Review Committee” means not only the members of a “Peer Review Committee” but also all of the committee’s representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serve on a peer review committee in any capacity whether such person is acting as a member or is under a contract or other formal agreement with the committee, and any person who participates with or assists the committee with respect to its actions.

“Policies” or **“Policies and Procedures”** means statements delineating a guiding principle

or philosophy intended to influence decisions to determine a course of action, as well as a description of the methodology to achieve the results desired. Medical Staff "Policies" must be approved by the Medical Executive Committee and are attendant to the Bylaws of the Medical Staff, as are the Rules and Regulations. All Medical Staff Policies approved by the Medical Executive Committee must be communicated to the entirety of the Medical Staff in a timely fashion.

"Practitioner" unless otherwise specified, means a member of the Medical Staff holding Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, or Doctor of Podiatric Medicine degrees.

"Precautionary" means action done without delay or formality as an interim step and does not imply any final finding.

"Privileges" or **"Clinical Privileges"** means the permission granted to a Practitioner to provide specific services to patients, in the Hospital. The Practitioner shall be granted reasonable access to Hospital equipment, facilities, and personnel necessary to effectively exercise such privileges in accordance with these Bylaws.

"Reconciliation Committee" means a committee comprised of three (3) members of the Board of Directors, three (3) members of the Medical Staff, and three (3) members of the Hospital Administration which convenes when there is disagreement between the Medical Executive Committee and the Hospital Board of Directors on an Adverse Recommendation vs. a Practitioner.

"Rules and Regulations" means statements that exert control and direction. "Rules and Regulations" must be approved by the Medical Executive Committee and are attendant to the Bylaws of the Medical Staff as are the Medical Staff Policies. The Active Medical Staff shall have the opportunity to review and make recommendations regarding any proposed revisions to the Rules and Regulations prior to any action being taken by the Medical Executive Committee. Any amendments to the Rules and Regulations passed by the Medical Executive Committee must be communicated to the entire Medical Staff in a timely fashion.

"Telemedicine" means the use of medical information exchanged from one site to another via electronic communications to assist in the care of the patient and/or the education of the patient or health care provider and for the purpose of improving patient care.

ARTICLE I: NAME

The name of this organization shall be Parkview LaGrange Hospital Medical Staff.

ARTICLE II: MEMBERSHIP

Section 1. Medical Staff Membership

Membership on the Medical Staff at Parkview LaGrange Hospital is an authorization to exercise only such Clinical Privileges as are specifically granted, and shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated Rules, Regulations, and Policies of the Medical Staff and Hospital.

Section 2. Qualifications for Medical Staff Membership

To be eligible for Membership on the Medical Staff at Parkview LaGrange Hospital a Practitioner must hold an unrestricted Indiana license as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dentistry (D.D.S. or D.M.D.), or Doctor of Podiatric Medicine (D.P.M.). Unless otherwise exempted (e.g. Pathology, Radiology) they must have a current unrestricted State Controlled Substance Registration (CSR) and Drug Enforcement Association (DEA) number. They must carry malpractice insurance, which covers them for their exercise of those Clinical privileges requested. They must be “qualified” as a healthcare provider as defined in the Indiana Malpractice Act. They must have never had a suspension of their Medical License for reasons of professional conduct or competence or an exclusion from participation in Medicare or Medicaid for any reason. They must never have been convicted of, or entered a plea of, guilty or “no contest” to any felony relating to controlled substances, illegal drugs, insurance or health care fraud, violent crime, or abuse. In addition, they must demonstrate that they do not have a pattern of illegal activity such as repeated misdemeanor convictions relating to the same. Medical Staff members who fail to continuously meet these eligibility requirements during a period of appointment shall be deemed to have automatically relinquished their Clinical Privileges.

In addition to the above requirements, a Practitioner must be able to document their background, experience, education, training, current competence, good judgment, and ability to safely perform any privileges requested. They must adhere to the ethics of their profession, have a good reputation, and be able to work with others. The foregoing must be present 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 quality medical care.

No Practitioner shall be entitled to appointment on the Medical Staff or to exercise any particular Clinical Privileges in the Hospital merely by virtue of the fact that they are duly licensed to practice medicine, dentistry, or podiatry in this or any other state, or that they are a member of any professional organization, or that they have in the past, or presently have such privileges at this Hospital or any other hospital.

Section 3. Responsibilities of all Medical Staff Members

The responsibilities of all members of the Medical Staff are to:

- A. Abide by the Bylaws, Rules and Regulations, and Policies of the Medical Staff.
- B. Abide by the Principles of Medical Ethics as defined by their applicable professional association including the American Medical Association, American Osteopathic Association, American Dental Association, or American Board of Podiatric Surgery.
- C. Agree to and recognize the Hospital's obligation to query and report adverse actions to the National Practitioner Data Bank as established by federal statute. (Information obtained by query of the Data Bank will be used in evaluating the Practitioner's qualifications for initial or continued membership and if applicable, privileges granted.)
- D. Maintain personal medical malpractice insurance coverage to cover the scope of Privileges requested in accordance with the Indiana Medical Malpractice Law (IC 34-18).
- E. Exercise only those privileges granted by the Board of Directors.
- F. Provide emergency medical care for any patient following accepted guidelines of his or her respective specialty society. (Any member with delineated Clinical Privileges may provide any type of emergency care in a life threatening situation or a situation that threatens serious harm, provided that the care provided is within the scope of the individual's license.)
- G. Provide appropriate and timely care to those patients for whom they are assigned as attending or consulting physician, or to ensure that an appropriately privileged physician provides this care.
- H. Ensure that all Hospitalized patients are visited daily by their Attending or another Medical Staff Member designated by the Attending. Hospice and Swing Bed patients are excluded from this requirement.
- I. Comply with clinical practice protocols and guidelines as established by and subsequently reported to regulatory or accrediting agencies or patient safety organizations including those related to national patient safety initiatives and core measures. Clinical reasons for any variance are to be clearly documented.
- J. Demonstrate competency in the use of the Hospital's Electronic Medical Record (must meet this requirement in order to exercise Clinical Privileges) and document using that record as appropriate (includes the use of Computerized Physician Order Entry).
- K. Complete in a timely fashion all medical records for the patients for whom care is provided in the Hospital.
- L. Inform the Medical Staff in a timely manner of any formal actions initiated that could result in a change to licensure, state or federal controlled substance registration, professional liability insurance coverage, or voluntary or involuntary reduction of Clinical Privileges at other health care institutions. (Pending litigation and final judgments or settlements for any malpractice activity must be reported.)
- M. Report the filing of any felony charges against them.
- N. Ensure appropriate authorization is obtained, and assume medical and legal responsibility for Allied Health Practitioners performing duties on their behalf, as described in associated policies.
- O. Ensure appropriate authorization is obtained, and appropriately supervise

- students, interns, medical residents, and other non-M.D./D.O., D.D.S., D.M.D., D.P.M. practitioners who have not been granted Clinical Privileges.
- P. Cooperate with and participate in performance improvement and peer review activities, whether related to self or others.
 - Q. Hold harmless those participants performing peer review activities related to them with such peer review to be performed without malice and in good faith.
 - R. Maintain the confidentiality of the peer review process recognizing no right to discovery of the peer review of other Medical Staff members.
 - S. Work with other Medical Staff members, nurses, ancillary staff, support staff, Hospital Administration, Hospital Board of Directors, and other individuals and organizations in a cooperative, professional, and civil manner refraining from any activity that is disruptive to the Hospital or Medical Staff operations.
 - T. Refuse to engage in improper inducements for patient referral.
 - U. Meet the Continuing Medical Education requirements as per associated Medical Staff CME policy.
 - V. Report any health condition that may adversely affect the ability to provide quality care for patients.
 - W. Pay medical staff dues and assessments, if required.
 - X. Uphold the privacy rights of the patients.

Compliance with the above is necessary to apply for and/or maintain Medical Staff membership.

Section 4. Rights of all Medical Staff Members

- A. To exercise those privileges granted by the Hospital Board of Directors.
- B. To have reasonable access to Hospital equipment, facilities, and personnel to effectively exercise such privileges in accordance with these Bylaws.
- C. Unless otherwise stated, in the event of an Adverse recommendation regarding appointment or reappointment to the Medical Staff or any recommendation to restrict or deny Clinical Privileges, applicants to the Medical Staff as well as Medical Staff members have the right to the hearing and appeal process as provided in these Bylaws.

Section 5. Non-discrimination

Medical Staff membership and/or Clinical Privileges shall not be denied on the basis of color, sexual orientation, gender, gender identity, race, age, creed, national origin, or disability.

ARTICLE III: CATEGORIES OF MEMBERSHIP

The Medical Staff shall be divided into Active, Affiliate, and Emeritus categories. All Medical Staff members, including Contract Physicians as described in Section 4 of this Article, shall be assigned to one of these categories.

Section 1. The Active Medical Staff

The Active Medical Staff shall consist of those Medical Staff Members who routinely utilize the Hospital services and exercise those privileges granted by the Hospital Board of Directors to provide care for their patients, and who assume all the functions and responsibilities of appointment to the Active Medical Staff. Active Medical Staff members must have Clinical Privileges.

The following rights and responsibilities of Active Staff members are in addition to Article II, Sections 3 and 4 of these Bylaws:

- A. To assist in the clinical and administrative work as required for successful Hospital and Medical Staff operation.
- B. To participate in Emergency Department call coverage for unattached patients unless otherwise exempted by the Medical Executive Committee (when such coverage is provided by a contracted group).
- C. To participate on those committees assigned as a member with vote.
- D. To attend at least one-third of any assigned committee meetings including the Medical Executive Committee to which all Active Medical Staff are assigned.

Section 2. The Affiliate Medical Staff

The Affiliate Medical Staff shall consist of those Practitioners who are otherwise qualified, but do not utilize the Hospital as their primary facility for medical practice. Unless otherwise stated, Affiliate Medical Staff members must maintain Active Staff Privileges at another facility that requires participation in quality management activities consistent with those of Parkview LaGrange Hospital. Dentists are exempted from the requirement of Active Staff membership at any hospital but must provide sources from which documentation of current competence for purposes of appointment and reappointment can be obtained. If an Affiliate Medical Staff member has not requested Clinical Privileges, or requests "Outpatient Only" privileges, or privileges only in Occupational Health or Emergency Medicine, then Active Staff membership at another hospital is not required. The following rights and responsibilities of Affiliate Staff members are in addition to Article II, Sections 3 and 4 of these Bylaws:

- A. Practitioners are not required to attend regular Medical Staff meetings or serve on committees but are welcome to do so.
- B. Practitioners may serve on any committee with vote, if appointed, except the Medical Executive Committee.
- C. Practitioners are not eligible to vote at Medical Staff meetings, serve as Chair of any committee, or hold any office of the Medical Staff.

Section 3. The Emeritus Medical Staff

The Medical Staff President, in consultation with the Medical Staff Officers, may confer the title of Emeritus Medical Staff Member upon those retiring/departing Members who have maintained a longstanding relationship with the Hospital and have been members in good standing. Emeritus Medical Staff Members are ineligible for Clinical Privileges. Except as described below, qualifications for Medical Staff membership described in Article II, Section 2 as well as responsibilities for membership described in Article II, Section 3 shall be waived.

The following rights and responsibilities of Emeritus Medical Staff members are:

- A. To work with other Medical Staff members, nurses, ancillary staff, support staff, hospital administration, Hospital Board of Directors, and any other Hospital associates in a cooperative, professional, and civil manner refraining from any activity that is disruptive to the Hospital or Medical Staff operations.
- B. Practitioners are not required to attend Medical Staff meetings but are welcome to do so without vote.
- C. Practitioners are not eligible to serve as Chairperson of any committee or hold any office of the Medical Staff excepting the Ethics Committee where they may serve in any capacity assigned.

Section 4. Contract Physicians

Contract physicians shall consist of those Practitioners who provide services as contracted with the Hospital including Anesthesia, Pathology, Radiology, Hospitalist and Emergency Room physician coverage. The group contracting with the Hospital shall designate at least one (1) and no more than two (2) representatives to serve on the Active Medical Staff. The remaining physicians shall be assigned to the Affiliate Staff category.

Section 5 Residents

Although residents are not members of the Medical Staff, the Medical Staff acknowledges and supports the presence and activities of residents. The residents are physicians in training who are authorized to perform patient care activities under the supervision and credentials of attending physicians as outlined by specific agreements between Parkview LaGrange Hospital and selected residency programs.

Section 6. Leave of Absence (LOA)

Any member of any category may request a Leave of Absence (LOA) from the Medical Staff as described in the LOA policy.

ARTICLE IV: MEDICAL STAFF CREDENTIALING

Section 1. Applicant Requirements

For consideration for initial appointment, reappointment, and, if applicable, initial, renewed, or increased privileges, all applicants, including those desiring to provide services via Telemedicine, must:

- A. Meet the qualifications for Medical Staff Membership (Article II, Section 2), the qualifications for a specific category of membership (Article III, Sections 1-3), and fulfill the eligibility requirements for those Clinical Privileges requested (if any).
- B. Accept and comply with the Responsibilities for Medical Staff Membership (Article II, Section 3) as well as the responsibilities appropriate to the staff category requested.
- C. Accept the burden of producing adequate information for a proper evaluation of competence, character, and ethical behavior. Supply reasonable evidence of current ability to perform the Privileges requested, and other qualifications as outlined in associated Medical Staff policies and application forms, including but not limited to:
 - 1. Previously successful or currently pending challenges to any licensure or registration (state or district; Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration.
 - 2. Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at another hospital or other health care organization.
 - 3. Involvement in a professional liability action, reporting at a minimum pending litigation and final judgments or settlements.
 - 4. Charges filed for any felony.
- D. Signify willingness to appear for interviews in regard to the application and so respond if requested.
- E. Authorize consultation with members of the Medical Staff of other institutions with which the applicant has been associated and with any others who may have information bearing on competence, character, ethical qualifications, and ability to carry out the Clinical Privileges requested. This authorization includes information from any Central Verification Organization.
- F. Release from liability all representatives of the Hospital and Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and their credentials, and all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for Staff appointment and, if applicable, Clinical Privileges, including otherwise privileged or confidential information.
- G. Have sufficient patient care contact within the Practitioner's practice to permit the Hospital to evaluate the Practitioner's current clinical competence for any Clinical Privileges, whether being initially requested, renewed, or already granted.

Section 2. Applicant Assessment

All applicants for initial appointment, reappointment, and if applicable, initial, renewed, or increased Clinical Privileges will be evaluated for:

- A. Quality of patient care: compassionate, appropriate, effective, reflecting good judgment
- B. Medical/Clinical Knowledge: initial/continued education and its application in practice
- C. Practice based learning and improvement: use of evidence based medicine, involvement with performance improvement activities
- D. Interpersonal and communication skills: ability to work with patients, staff, and colleagues. Ability to document well.
- E. Professionalism: sense of responsibility, sensitivity to diversity, ethical behavior
- F. Systems based practice: co-ordination of care, teamwork, appropriate resource utilization

Practitioner specific information is considered and compared to aggregate information when these measurements are appropriate for comparative purposes. Appropriate verifications will be obtained from primary or other Joint Commission approved sources, according to associated Medical Staff policies and forms, whenever possible, and will at a minimum include:

- A. Current licensure
- B. Relevant training and experience
- C. Current competence
- D. Ability to perform the privilege(s) requested, if any
- E. National Practitioner Data Bank (NPDB) query
- F. Peer recommendations
- G. Review and recommendation by the appropriate Clinical Advisor

- H. A Practitioner who has minimal patient encounters at Parkview LaGrange Hospital may be designated as “Low or No Volume”. For purposes of this designation, encounters are defined as admissions, procedures, treatments, or consults. In the case of low or no volume Practitioners, verifications and/or case logs from facilities where the applicant performs significant clinical activity and/or peer references may be obtained to document evidence of current competence.

Section 3. Delegation

The Medical Staff may delegate the verification portion of the credentialing process to other resources including Central Verification Organizations (CVO's) while maintaining authority for final approval of recommendations for membership and privileges.

Section 4. Clinical Privileges

Every initial or reappointment application must contain a written request for the specific

Clinical Privileges desired (if any) which will be evaluated as described in Section 2 of this Article with focus on current competence. A request for Privileges that are covered by an exclusive contract will not be considered unless the applicant is a member of the group holding the exclusive contract. In like manner, Clinical Privileges already granted may not be exercised unless the Practitioner is a member of the group holding the exclusive contract unless the contract provides exception.

In addition, periodic re-determination of Clinical Privileges and the increase or reduction of same shall be based upon: an individual's documented experience in specific clinical service areas or with specific procedures; the results of treatment; and the conclusions drawn from organization performance improvement activities when available.

In processing a request for Telemedicine Privileges, the applicant shall be considered in accordance with the provisions of this Article in the same manner as any other applicant.

All initially granted Clinical Privileges, whether granted at the time of appointment, reappointment, or during a period of appointment, shall be considered provisional and may be subject to one hundred percent review for up to one year. Concerns arising from this review will be brought to the attention of the Medical Staff Member on an ongoing basis via the established peer review process.

If a Member of the Medical Staff who has been granted Clinical Privileges on a provisional basis fails to participate in the required number of cases or fails to co-operate with the monitoring and review process, the Clinical Privileges shall be automatically relinquished at the end of the provisional period. This relinquishment shall afford no hearing or appeal.

If, however, based on the evaluation performed during the provisional period, Clinical Privileges are revoked or restricted for reasons related to clinical competence or professional conduct, the Practitioner shall be entitled to a hearing and appeal as described in these By-Laws.

Section 5. Processing

All inquiries regarding appointment or re-appointment to the Medical Staff should be directed to the Medical Staff Services office.

- A. All applications for initial appointment, reappointment, and if applicable, initial, renewed, or increased Clinical Privileges will be processed thoroughly and as expeditiously as possible as outlined in the associated Medical Staff policies. In the event of unwarranted delay on the part of the Medical Executive Committee in making a recommendation to the Hospital Board of Directors (70 days from the date of initial presentation of a completed, verified application), the Board may act without such recommendation on the basis of documented evidence of the applicant's or Staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.
- B. In the case of reappointment, if there is delay in processing an application due to a

Practitioner's failure to complete and return the reappointment application and materials in a timely manner, or to provide requested documentation, the Applicant's appointment and any associated Clinical Privileges shall automatically expire at the completion of the period of appointment.

C. Recommendation for the granting of any or all of the following will progress from the Clinical Advisor for a given patient care area, to the Administrative Committee, and then to the Medical Executive Committee.

1. Initial Medical Staff membership
2. Initial Privileges
3. Renewal of Medical Staff membership
4. Renewal or modification in Privileges

Favorable recommendations from the Medical Executive Committee will be forwarded to the Hospital Board of Directors for approval. Adverse Recommendations will follow the Hearing and Appeal process as defined in Article VI of these By-Laws.

Section 6. Provisions of Appointment

- A. Appointment to the Medical Staff does not guarantee that any Clinical Privileges shall be granted. Only such Privileges specifically granted by the Board of Directors, in accordance with these Bylaws and associated policies, shall be conferred.
- B. Appointments for membership and, if applicable, Privileges shall be made for a period of not more than two (2) years.

Section 7. Temporary and Disaster Privileges

The Hospital President or their designee with the approval of the President of the Medical Staff or their designee in accordance with the associated Medical Staff Policies may grant temporary Privileges. Likewise, in the event of a disaster as defined by the Hospital disaster plan, Privileges shall be granted in accordance with the Disaster Privileges Policy.

ARTICLE V: PEER REVIEW ACTIONS

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. Whenever the activities or professional conduct of any Member of the Medical Staff might be considered to be below the standards of the Medical Staff, or to be disruptive to the operations of the Medical Staff or the Hospital, peer review action with respect to such Practitioner may be requested by any Practitioner of the Medical Staff, by the President of the Hospital, or by any member of the Board of Directors. For purposes of Peer Review Actions and Hearing and Appeal, the Medical Staff Officers shall function with the full authority of the Medical Executive Committee. Requests for peer review shall be directed to the QRM Committee and evaluated as per the QRM plan, or, should the QRM Committee deem it appropriate, the concerns may be directly referred to

the Medical Executive Committee for review.

Section 1. Collegial Intervention

These Bylaws encourage the use of progressive steps including the initial use of collegial intervention to address issues of clinical competence and/or professional conduct. With this in mind, the QRM Committee, the Medical Executive Committee, or the Physician Assistance Committee may in instances deemed appropriate and in the exercise of their discretion, address and respond to a request for peer review action by recommending any or all of the following.

1. Evaluation
2. Education
3. Guidance
4. Monitoring
5. Proctoring
6. Counseling

These interventions are intended to promote a collegial and educational approach to address the concerns that have been identified. All efforts of Medical Staff Leadership in this regard are intended to be part of the Hospital's quality improvement and professional review activities. Participation in a collegial intervention is voluntary on the part of the affected Practitioner and its use is discretionary for the Committees listed. Further, this informal procedure is considered confidential peer review activity and shall not in and of itself give rise to procedural rights. If in the judgment of the Medical Executive Committee or the President of the Hospital, the Collegial intervention does not produce the expected performance improvement, or if the affected Practitioner does not wish to participate in the collegial process, then the Medical Executive Committee shall make a recommendation as to the appropriate action to be taken. If a formal evaluation is recommended, then the procedures and rights set forth in Section 2 of this Article shall be applicable.

Section 2. Formal Peer Review Action

When the collegial procedure as delineated above in Section 1 is either deemed inappropriate or has failed in achieving the outcomes desired, the following formal procedure of peer review may be followed.

- A. All requests for formal peer review action shall be in writing and shall be made to the Medical Executive Committee. The request shall be supported by reference to the specific activities or conduct that constitutes the grounds for the request. The Medical Executive Committee shall review all requests for formal peer review action and if the concern appears to have merit the Medical Executive Committee Chair may appoint a preliminary inquiry committee (collectively referred to as the "Inquiry Body") to assist in the review of such request. A formal investigation shall be deemed instituted should an "Inquiry Body" be appointed. Should an Inquiry Body be appointed, notification that a formal investigation has been initiated shall be sent to

- the affected Practitioner and the Hospital President.
- B. Members of the Inquiry Body shall not include partners, associates, or relatives of the Practitioner under investigation, but shall include peers and may include Practitioners from other Medical Staffs. In addition to reviewing any or all materials deemed necessary, and interviewing any individuals deemed appropriate, the Inquiry Body shall have the express authority to request a physical and/or mental evaluation of the Practitioner involved.
 - C. Within forty-five (45) days after convening for the purpose of investigating allegations of care or professional conduct below Medical Staff standards, the Inquiry Body shall issue a report of its review. All efforts shall be made for completion of the report in this time frame, but the committee may be granted additional time particularly if outside review is requested. Prior to making the report, the Inquiry Body may invite the Practitioner against whom the peer review action has been requested to come for an interview. This interview shall not constitute a hearing and shall be a preliminary inquiry in nature. An accurate record of such interview shall be made and included with the Inquiry Body report. The mechanism for recording such interview may be accomplished by use of a stenographer, electronic recording unit, or by the taking of adequate minutes.
 - D. Within thirty days following receipt by the Medical Executive Committee of a report from an Inquiry Body, the Medical Executive Committee shall take action upon the request. The affected Practitioner shall be invited to make an appearance before the Medical Executive Committee prior to its taking such action. This appearance shall not constitute a hearing and shall be preliminary in nature. The Medical Executive Committee shall make an accurate record of such appearance. The mechanism for recording the interview may be accomplished by use of a stenographer, electronic recording unit, or by the taking of adequate minutes.
 - E. The action of the Medical Executive Committee on a request for peer review action includes but is not necessarily limited to the following:
 - 1. Reject the request
 - 2. Issue a warning or letter of reprimand
 - 3. Impose terms of probation or a requirement for consultation
 - 4. Require additional training
 - 5. Recommend to the Hospital Board of Directors reduction or revocation of any or all of the Practitioner's Clinical Privileges
 - 6. Recommend to the Hospital Board of Directors revocation of the Practitioner's Medical Staff appointment
 - F. Any recommendation by the Medical Executive Committee to issue a letter of reprimand, impose a period of probation, or require consultation and/or additional training shall not entitle the affected Practitioner to the hearing and appeal procedure described in Article VI of these Bylaws. The Practitioner shall be entitled to place a letter in his/her Peer Review file setting forth their position with regard to any such recommendation for future reference.
 - G. Any recommendation by the Medical Executive Committee for reduction or revocation of any or all of a Practitioner's Clinical Privileges, or for revocation of

Medical Staff appointment, shall entitle the affected Practitioner to the hearing and appeal procedure set forth in these Bylaws.

Section 3. Precautionary Suspension

- A. Any 3 (three) of the following (one of whom shall be a Medical Staff Officer) shall have the authority to suspend any or all of the Clinical Privileges of a Member of the Medical Staff whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual.
1. Any officer of the Medical Staff
 2. The chairperson of any standing committee of the Medical Staff
 3. The President of the Hospital
 4. The Medical Director/Chief Medical Officer

Except as in C below, felony charges for crimes involving all but taxation and property shall in every case result in a Precautionary Suspension of Clinical Privileges pending review.

- B. In addition to the authority to precautionarily suspend any or all of a Practitioner's Clinical Privileges, as an alternative to a Precautionary Suspension, any 3 (three) of those same individuals listed above may at their discretion and on behalf of the Medical Staff enter into a voluntary agreement with the Practitioner to not exercise their Clinical Privileges pending review and if applicable investigation of the matter.
- C. A Precautionary Suspension shall be deemed an interim precautionary step in the quality improvement and professional review activity related to the ultimate professional review action that may be taken with respect to the suspended Practitioner but is not a complete professional review action in and of itself. The Precautionary Suspension shall not imply any final finding of responsibility for the situation that gave rise to the suspension. Such Precautionary Suspension shall become immediately effective upon imposition and shall be reported to the President of the Hospital or their designee, the Medical Director, and the President of the Medical Staff. The Medical Staff President shall assign the responsibility for the care of the suspended Practitioner's patients to another Practitioner of the Medical Staff with appropriate Clinical Privileges. The wishes of the Practitioner and the patient shall be considered in the selection of the Practitioner assigned to provide such care.
- D. Within a reasonable time period, not to exceed 72 hours from the imposition of a precautionary suspension, an ad hoc committee (Inquiry Body) consisting of at least three active members of the Medical Staff shall be appointed by the Chair of the Medical Executive Committee. Such committee shall be responsible for reviewing the Precautionary Suspension and related circumstances leading to the same. All efforts shall be made to appoint committee members who are not in direct competition with the affected Practitioner. No member of the Inquiry Body shall have actively participated in the precautionary suspension. Within seven (7) days, this ad hoc committee shall make a report/recommendation to the Medical Executive Committee with regard to their findings. The Medical Executive

- Committee shall meet within seven (7) days to act on this report/recommendation. Prior to acting on this report/recommendation the affected Practitioner shall be given the opportunity to address the Medical Executive Committee concerning the issues under investigation and the conditions the committee may impose. In no event shall this meeting constitute a hearing within the meaning of Article VI, nor shall any procedural rules apply.
- E. After review, the Medical Executive Committee shall decide whether or not to continue, modify, or terminate the Precautionary Suspension. In addition, the Committee shall decide whether to recommend no intervention, collegial intervention, performance improvement activities, or make an Adverse Recommendation vs. the Practitioner's Clinical Privileges or Medical Staff Appointment. Should a Precautionary Suspension exceed 30 days, or an Adverse Recommendation be made, then the affected Practitioner shall be entitled to the procedural rights of the Hearing and Appeal procedure as set forth in Article VI of these Bylaws.

Section 4. Automatic Relinquishment of Clinical Privileges

A Member of the Medical Staff may have been deemed to have relinquished any or all of their Clinical Privileges in the following instances without affording that Practitioner the procedural rights to a hearing and appeal procedure as provided in Article VI of these Bylaws.

- A. Failure to complete Medical Records in a timely fashion as described in Medical Staff Rules and Regulations.
- B. Failure to maintain professional liability insurance coverage to cover the scope of Privileges granted in the amounts required by Medical Malpractice Law (IC 34-18).
- C. Failure to pay dues or assessments as required by the Medical Executive Committee.
- D. Failure to produce documentation of current unrestricted Indiana licensure.
- E. Failure to produce evidence of current DEA or CSR unless exempted
- F. Failure or refusal to meet any special appearance requirement or request made by the Medical Executive Committee
- G. Failure to provide information reasonably requested by the Medical Executive Committee to include by way of example and not limitation:
 - 1. Information regarding a professional review action or a resignation from another facility.
 - 2. Information deemed necessary to address questions that have arisen during the course of credentialing and/or peer review.
- H. Action taken by the State Board of Medical Examiners or the Drug Enforcement Agency restricting or placing on probation a Practitioner's license, DEA, or CSR shall in like fashion cause automatic relinquishment of any Clinical Privileges which the Medical Staff Member has been granted which are within the scope of the limitation or restriction.

The affected Practitioner shall be notified of the Automatic Relinquishment of Privileges in writing via certified mail return receipt requested. The notification must outline what response is required to reinstate the Practitioner's Privileges as well as the timeframe for receipt of a response and the consequences if the Practitioner fails to respond. If the Practitioner fails to meet the requirements for reinstatement of Privileges within 60 days of the date outlined in the notification letter, the Practitioner shall be considered to have resigned his appointment to the Medical Staff.

ARTICLE VI: HEARING AND APPEAL PROCEDURE

Section 1: Right to Hearing

- A. When in the reasonable belief that an action is in furtherance of quality care, the Medical Executive Committee makes a recommendation to:
1. Deny initial appointment to the Medical Staff
 2. Deny reappointment to the Medical Staff
 3. Revoke appointment to the Medical Staff
 4. Deny requested Clinical Privileges for which the Practitioner is otherwise deemed eligible by training, education, and experience (unless denied because the requesting Practitioner is not a member of the group holding an exclusive contract to provide the services requested or the Hospital does not offer the services for which Privileges have been requested)
 5. Recommend revocation of any or all Clinical Privileges previously granted
 6. Suspend Clinical Privileges for more than 30 days (other than for an Automatic Relinquishment) Mandate concurrent consultation (where the consultant must approve the course of treatment in advance)
 7. Deny reinstatement from a leave of absence if the reasons relate to professional competence or conduct

Such recommendation shall constitute an Adverse Recommendation and shall entitle the Practitioner to a hearing before a Hearing Committee of the Medical Staff as described in Section 5 of this Article.

- B. In the same manner, should the Board of Directors decide to proceed with any of the above listed actions, such recommendation shall entitle the Practitioner to a hearing before a Hearing Committee of the Medical Staff as described in Section 3-5 of this Article.

Section 2: Request for Hearing

- A. Upon a Practitioner's receipt of an Adverse Recommendation from the Medical Executive Committee (as described above in Section 1A) or the Hospital Board of Directors (as described above in Section 1B), the Practitioner shall be notified of the following by the Chair of the Medical Executive Committee.

1. That an Adverse action against the Practitioner has been proposed
 2. The reason(s) for the proposed Adverse action (This should include the criteria upon which Medical Staff members are evaluated and the manner in which the Practitioner failed to meet the standard)
 3. That the Practitioner has a right to request a hearing concerning the proposed action
 4. The time limit within which the Practitioner must request a hearing concerning the proposed action
 5. A summary of the Practitioner's rights in the hearing
- B. A Practitioner who desires to exercise their right to a hearing must provide a request to do so in writing to the chair of the Medical Executive Committee. Failure of a Practitioner to demand a hearing to which they are entitled by these Bylaws within thirty (30) days from the date of receipt of the notification described in Section 2A above shall be deemed a waiver of the Practitioner's right to such hearing and to any appellate review to which they might otherwise have been entitled. The recommendation shall become effective immediately when acted upon by the Hospital Board of Directors.
- C. Within ten (10) days after receipt of the demand for a hearing from a Practitioner entitled to the same, the Medical Executive Committee shall schedule and arrange for such a hearing and shall notify the Practitioner of the time, date, and location of the hearing. The hearing date shall be not less than thirty (30) days from receipt of the demand for a hearing unless the hearing is for a Practitioner who is already under suspension. In this case, the Hearing shall be held as soon as arrangements can reasonably be made but not less than ten (10) days from the date of receipt of the Practitioner's request for a hearing.
- D. The Practitioner and the Medical Staff Executive Committee or its designee may mutually agree to waive any of the hearing deadlines set forth in this Section and schedule such hearing on a date that is mutually acceptable to both parties. All correspondence with regard to hearings shall be made by certified mail, return receipt requested. This correspondence shall include but is not necessarily limited to the dates, times, and locations of hearings; the rights of the affected Practitioner to have hearings and subsequent appeals; the records of any proceedings; the final determinations made by the Medical Executive Committee and/or the Hospital Board of Directors.

Section 3. Hearing Committee Appointment

Upon receipt of a request for a hearing as described above in Section 2B, the Medical Executive Committee, shall appoint the members and Chair of a Hearing Committee. This committee shall be composed of not less than three (3) Active Members of the Medical Staff.** No member of this committee shall be in direct competition with the affected Practitioner, and no member of this committee shall have actively participated in the deliberations leading to the Adverse Recommendation. This exclusion extends to all Medical Staff Officers, the person who made the original request for corrective action (if

any), and to any member of the Hospital Board of Directors. Knowledge of the matter involved shall not preclude a member of the Medical Staff from service as a member of the Hearing Committee.

**In the event that it is not feasible to appoint a Hearing Committee from the Active Medical Staff, the Medical Executive Committee may appoint members from other Medical Staff categories. In some instances, in order to meet the criteria delineated for Membership on the Hearing Committee Medical Staff Members from other Parkview Health Hospitals may be appointed to serve on this committee.

Section 4. Pre-Hearing Conference

A “reasonable” time prior to the conduct of the hearing, a pre-hearing conference shall be held for the purpose of resolving any procedural matters as well as any objections or questions that might have arisen. Witness lists and documents to be submitted at the hearing are to be exchanged before the pre-hearing conference. In addition, the affected Practitioner shall identify the attorney or other person who will assist them at the hearing prior to this conference. The Chair of the Hearing Committee shall provide notice of the date and time of the pre-hearing conference to the Medical Executive Committee and to the affected Practitioner. Those present at the pre-hearing conference shall include the Chair of the Hearing Committee, the counsel and/or representative of the Medical Executive Committee, the affected Practitioner, and their counsel/representative. Failure by the Practitioner to raise an objection regarding any matter discussed to the Pre Hearing conference, including the membership of the Hearing Committee, shall be deemed a waiver unless otherwise approved by the Chair.

Section 5. Conduct of Hearing

- A. There shall be at least a majority of the members of the Hearing Committee present when the hearing takes place, and no member may vote by proxy.
- B. At the discretion of the Chair of the Hearing Committee, a representative of the Hospital Administration may be invited to be present without vote.
- C. An accurate record of the hearing must be kept. The mechanism shall be established by the Chair of the Hearing Committee and may be accomplished by use of a stenographer, electronic recording unit, or by the taking of adequate minutes. Copies of the proceedings shall be made available to the affected Practitioner upon payment of any reasonable charges.
- D. A Practitioner who fails to appear at such a hearing without good cause shall be deemed to have waived their rights in the same manner as provided in Section 2B of this Article of these Bylaws, and to have accepted the recommendation or decision involved. The recommendation shall thereupon become effective immediately when acted upon by the Hospital Board of Directors.
- E. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Hearing Committee. Granting of such postponement shall only be for good cause and at the sole discretion of the Committee Chair.
- F. The Chair of the Hearing Committee or their designee shall preside over the

- Hearing. They will determine the order of procedure during the Hearing, assure that all participants in the Hearing have a reasonable opportunity to present relevant oral and documentary evidence, and maintain decorum.
- G. The affected Practitioner shall be entitled to call, examine, and cross-examine witnesses; to present evidence relevant to the hearing; and to submit a written statement at the close of the hearing. The Practitioner may be represented by an attorney or other person of their choosing during the course of the proceedings, but this representative shall not be entitled to call, examine, or cross-examine witnesses; nor shall they present evidence. A Practitioner representing the Medical Executive Committee shall have all of these same rights.
 - H. The Hearing Committee may, without special notice, recess the hearing and reconvene at another time for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.
 - I. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The Hearing Committee may thereupon at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened.
 - J. Within ten (10) days after the final adjournment of the hearing, the Hearing Committee shall make a written report and will forward that report along with the hearing record and all associated documentation to the Medical Executive Committee. The report may recommend confirmation, modification, or rejection of the original Adverse Recommendation of the Medical Executive Committee or the Hospital Board of Directors. The affected Practitioner shall be entitled to receive the Hearing Committee's written report and recommendation as well.
 - K. If the recommendation of the Medical Executive Committee following such hearing is still adverse to the affected Practitioner, the Practitioner shall be entitled to an appellate review by the Hospital Board of Directors before the Hospital Board of Directors makes a final decision on the matter.

Section 6: Appeal to the Board of Directors

- A. Within thirty (30) days after receipt of a notice by an affected Practitioner of the continuation of an Adverse Recommendation by the Medical Executive Committee made after a hearing as above provided, the affected Practitioner may do the following by written notice to the Hospital Board of Directors.
 - 1. Demand an appellate review by the Hospital Board of Directors.
 - 2. Demand that the appellate review be held only on the record on which the Adverse Recommendation or decision is based.
 - 3. Demand that oral argument be permitted as part of the appellate review.
 - 4. Submit a written statement regarding those factual and procedural matters with which Practitioner disagrees. This statement shall specify the reasons for such disagreement and may cover any matter raised at any step in the procedure to which the appeal is related. If the Practitioner submits a written statement, then the Medical Staff may submit a similar statement within ten (10) days of receipt of the Practitioner's statement. If a statement is submitted by the Medical Staff,

the Hospital Board Chair shall provide a copy thereof to the affected Practitioner.

- B. If such appellate review is not demanded within thirty (30) days, the affected Practitioner shall be deemed to have waived their right to the same, and to have accepted the Adverse Recommendation or decision. The recommendation shall become effective immediately when acted upon by the Hospital Board of Directors.
- C. Within ten (10) days after receipt of a notice of demand for appellate review, the Chair of the Hospital Board of Directors shall schedule a date for such review and shall notify the Practitioner of the same. The date of appellate review shall not be less than fifteen (15) days or more than thirty (30) days from the date of receipt of the notice of demand for appellate review except that when the Practitioner demanding the review is under suspension in which case such review shall be scheduled as soon as arrangements can be reasonably made but not less than ten (10) days from the date of receipt of such notice. Postponement of appeal beyond the timeframes set forth in these Bylaws shall be made only for a good cause and at the sole discretion of the Chair of the Hospital Board of Directors.
- D. The appellate review shall be conducted by an Appellate Review Body consisting of all the members of the Hospital Board of Directors or by a duly appointed committee of members of the Hospital Board of Directors consisting of not less than three Directors. All action required of the Hospital Board of Directors may be taken by this committee of the Hospital Board of Directors duly authorized to act. The majority of the Members of the Appellate Review Body shall be present when the appellate review takes place and no member may vote by proxy. At the discretion of the Chair of the Appellate Review Body, a representative of the Hospital Administration may be invited to be present without vote.
- E. A "reasonable" time prior to the conduct of the appeal, a pre-appeal conference shall be held for the purpose of resolving any procedural matters as well as any objections or questions that might have arisen. The Chair of the Appellate Review Body shall provide notice of the date and time of the pre-appeal conference to the Medical Executive Committee and to the affected Practitioner. The affected Practitioner shall identify the attorney or other person who will assist them at the appeal prior to this conference.
- F. Those present at the pre-appeal conference shall include the Chair of the Appellate Review Body, the counsel and/or representative of the Medical Executive Committee, the affected Practitioner, and their counsel/representative
- G. Failure by the Practitioner to raise an objection regarding any matter discussed at the pre-appeal conference, including the membership of the Appellate Review Body, shall be deemed a waiver, unless otherwise approved by the Chair.
- H. The Appellate Review Body may seek counsel in fulfilling their duties, including but not limited to the Hospital's in house or external legal counsel.
- I. The Practitioner and the Medical Staff Representative may each be counseled by an attorney or other person of his/her choosing during the course of the proceedings, but these counselors shall not be entitled to call, examine, or cross examine witnesses, or to present evidence.
- J. The Appellate Review Body shall review the record created in the proceedings and shall consider the written statements submitted pursuant to paragraph A of this

Section for the purpose of determining whether the Adverse Recommendations against the affected Practitioner were justified and were not arbitrary, unreasonable, or capricious. If oral argument is demanded as a part of the review procedure, the affected Practitioner shall be present at such appellate review and shall be permitted to speak against the Adverse Recommendation, and shall answer questions put to them by any member of the Appellate Review Body. The Medical Executive Committee or the Hearing Committee, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in support of the Adverse Recommendation and who shall answer questions posed by any member of the Appellate Review Body. The Appellate Review Body may call any witnesses it deems necessary.

- K. New or additional matters not raised during the original hearing or in the Hearing Committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances and the Appellate Review Body shall in its sole discretion determine whether such new matters shall be accepted.
- L. The Appellate Review Body shall affirm the recommendation and subsequent decision of the Medical Executive Committee if the recommendation is supported by substantial evidence in the record of the hearing, if the recommendation will improve the quality of health care, if a reasonable effort was made to ascertain the facts before the recommendation was made, and if the procedures used in reaching the recommendation substantially complied with the Bylaws. If the Appellate Review Body determines that any of these review standards have not been met, it can either correct the deficiency or refer the matter to the Reconciliation process outlined in Section 7 of this Article.
- M. The appeal procedure shall not be deemed concluded until all of the procedural steps provided in this Section have been completed or waived.
- N. Within fourteen (14) days after the conclusion of the appeal procedure, the Appellate Review Body shall make its decision in the matter and shall send written notice thereof to the Medical Executive Committee and to the affected Practitioner. If this decision is in accordance with the Medical Executive Committee's last recommendation in the matter, it shall immediately become effective and final and shall not be subject to further hearing or appellate review. If this decision is contrary to the Medical Executive Committee's last such recommendation, the Appellate Review Body shall refer the matter to a Reconciliation Committee.

Section 7. The Reconciliation Committee

- A. The Reconciliation Committee shall be comprised of three (3) members of the Hospital Board of Directors, three (3) members of the Medical Staff, and three (3) members of the Hospital Administration chosen by those bodies for further review.
- B. This committee shall review all relevant materials from the Medical Executive Committee, the affected Practitioner, the Hearing Committee, and any documents from the Appeal to the Appellate Review Body. The Reconciliation Committee shall complete this review and make a recommendation to the Hospital Board of Directors within fourteen (14) days.
- C. At its next meeting, after receipt of the Reconciliation Committee's recommendation,

the Hospital Board of Directors shall make its final decision. This decision shall be immediately effective and final and shall not be subject to further hearing or appellate review.

- D. Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any matter that shall have been the subject of action by the Medical Staff or by the Hospital Board of Directors.
- E. Any applicant who has received a final Adverse decision regarding appointment or Clinical Privileges shall not be eligible to reapply for Medical Staff membership or for Clinical Privileges for a period of two (2) years. Any such reapplication 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.

ARTICLE VII: MEDICAL STAFF OFFICERS

Section 1. Officers of the Medical Staff

Officers of the Medical Staff shall include a President, Vice President, Secretary-Treasurer, and Immediate Past President.

Section 2. Qualifications of all Medical Staff Officers

Only those Active Staff appointees who satisfy the criteria listed below shall be eligible to serve as Medical Staff officers:

- A. Must be members of the Active Medical Staff at the time of election and throughout their term
- B. Must possess M.D. or D.O. degree
- C. May not concurrently be a Medical Staff Officer or serve on the Hospital Board of Directors of any other hospital
- D. May not be an owner of or investor in a competing Health System or have other significant conflict of interest with the Hospital/Health System
- E. Must have constructively participated in Medical Staff affairs demonstrating leadership abilities
- F. Must be willing to discharge faithfully the duties and responsibilities of the position to which they are elected

Failure to continuously meet the qualifications for office as delineated in Section 2A thru 2C of this article shall automatically create a vacancy in the office and no formal action for removal from office is required.

Section 3. Nomination and Election

- A. The President of the Medical Staff shall appoint a nominating committee in September or October of each year.
- B. The nominating committee shall consist of not less than three (3) members of the Active Medical Staff and no more than one (1) nominating committee member shall be a current Medical Staff officer.
- C. This committee shall annually review members of the Active Medical Staff and determine nominees for President, Vice President, and Secretary Treasurer. This slate of nominees shall be presented to the Medical staff membership at least 14 days prior to election. Additional nominations will be accepted prior to the election upon written request to the President of the Medical Staff.
- D. Medical Staff Officers shall be elected annually in November or December. Only members of the Active Medical Staff shall be eligible to vote.
- E. Voting shall be by motion, second, and consensus if there is only one nominee per office. If there is more than one nominee for office, voting shall be by written ballot. Absentee ballots delivered to the Medical Staff Services office prior to the election in person by a Medical Staff Member are acceptable and will be counted.
- F. A nominee shall be elected upon receiving a majority of votes cast. If no candidate receives a majority vote on the first ballot, a runoff election shall be held promptly between the two (2) candidates receiving the highest number of votes. A quorum of greater than fifty percent of the Active Medical Staff is required (including those voting by absentee ballot).
- G. Elected Officers shall take office effective January 1 each year.

Section 4. Term of Office

An Officer shall serve a one (1) year term in their respective office unless they resign or are removed as provided in these Bylaws. No officer may serve more than two (2) consecutive terms in any single office. Upon completion of their term or terms in the office of President of the Medical Staff, this officer shall automatically hold the position of Immediate Past President.

Section 5. Vacancies/ Removal from Office

- A. Vacancies in the offices of Vice President or Secretary Treasurer shall be filled by appointment by the Medical Executive Committee.
- B. The Vice President shall automatically fill a vacancy in the office of President.
- C. The most recent Past President who is qualified to hold the office shall fill a vacancy of the office of Immediate Past President.
- D. Removal of a Medical Staff Officer can be initiated by the Medical Executive Committee or by a petition signed by at least twenty five per cent (25%) of the Active Medical Staff. The members of the Medical Executive Committee or an ad hoc committee appointed by the Medical Executive Committee shall investigate any allegations and shall formulate a recommendation to be presented to the Active Medical Staff for final action. A special meeting of the Active Medical Staff shall be called for the purpose of discussion and a vote. Notice of this meeting shall be given at least fourteen (14) days in advance. Removal of an officer requires a vote

in favor of removal from office by three-fourths (3/4) of the Active Medical Staff including those voting by absentee ballot. To be counted, absentee ballots must be delivered to the Medical Staff Services office prior to the special meeting in person by a Medical Staff Member. The President and the Hospital Board of Directors shall be apprised of all actions. Conditions that warrant removal of an officer include but are not limited to;

1. Conduct detrimental to the interests of the Hospital or Medical Staff
2. Physical or mental infirmity that renders the individual incapable of fulfilling the duties of the office

Section 6. Responsibilities of Officers

A. The President shall

1. Serve as chairperson of the Medical Executive Committee and as an ex-officio member on all other Medical Staff committees.
2. Preside at the general meetings of the Medical Staff and assist in the creation of the agenda
3. Serve as a voting member on the Hospital Board of Directors attending both routine Board meetings and meetings of Board Committees as assigned.
4. Appoint members of any standing or ad hoc committees required to deal with specific issues as directed by the Medical Executive Committee, the Board of Directors, or requested by the Hospital Administration. They shall designate the Chairperson of these committees as well.
5. Ensure the enforcement of the Bylaws and the Rules and Regulations of the Medical Staff. This includes compliance with procedures involved where a corrective action has been recommended for a Medical Staff Member.
6. Serve as liaison between the Medical Staff, the Board of Directors, and the Hospital Administration.
7. Serve as public spokesperson for the Medical Staff.
8. Lead the Medical Staff in collaboration with the Hospital on Performance Improvement activities and their implementation.
9. Perform other functions in accordance with the Medical Staff Bylaws, or as assigned by the Medical Staff, or the Medical Executive Committee.

B. The Vice President shall

1. Assume the duties of the President in the event the President is unable to fulfill those obligations.
2. Serve as a voting member on the Hospital Board of Directors attending both routine Board meetings and meetings of Board Committees as assigned.
3. Remain knowledgeable about Medical Staff issues to ensure continuity of leadership in the Medical Staff President's absence.
4. Perform other functions in accordance with the Medical Staff Bylaws or as assigned by the Medical Staff President or the Medical Executive Committee.

C. The Secretary-Treasurer shall

1. With the assistance of Hospital support staff, assure that accurate minutes of all Medical Executive Committee and general Medical Staff meetings are maintained.
2. Assure the safeguarding and accounting for all funds of the Medical Staff.
3. Attend to all appropriate correspondence and notices on behalf of the Medical Staff and the Medical Executive Committee.
4. Remain knowledgeable about Medical Staff issues.
5. Perform other functions in accordance with the Medical Staff Bylaws or as assigned by the Medical Staff President or the Medical Executive Committee.

D. The Immediate Past President shall

1. Provide continuity of leadership advising and assisting the President of the Medical Staff.
2. Remain knowledgeable about Medical Staff issues.
3. Perform other functions in accordance with the Medical Staff Bylaws or as assigned by the Medical Staff President or the Medical Executive Committee.

In the event that a Medical Staff Officer is deemed ineligible for service on the Hospital Board of Directors, another Active Staff Member who meets eligibility criteria shall be selected by the Medical Executive Committee to assume this role.

ARTICLE VIII: ORGANIZATION OF THE MEDICAL STAFF

Section 1. The Medical Executive Committee

Other than the exception noted in ARTICLE V Section I (for peer review procedures), the Medical Executive Committee shall consist of the entire Active Medical Staff. This committee serves as the governing body of the Medical Staff as described in these Bylaws. The President of the Medical Staff shall serve as Chair of the Medical Executive Committee. The Hospital Board Chair, Hospital President, Vice President of Patient Services, Hospital Medical Director, and the Medical Staff Coordinator shall be non-voting members. This committee shall meet at least ten (10) times per year and a permanent record of the proceedings and actions shall be maintained. Unless otherwise noted in these Bylaws, a Quorum for the Medical Executive Committee shall exist when fifty percent (50%) of voting members are present.

The responsibilities of the Medical Executive Committee shall be:

- A. To represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.
- B. To review the Medical Staff Bylaws, Rules and Regulations, Policies and

- Procedures, and make recommendations regarding amendments to the same to the Hospital Board of Directors.
- C. To uphold the Bylaws and implement the approved Rules, Regulations, Policies, and Procedures of the Medical Staff.
 - D. To receive and act upon reports and recommendations from other Medical Staff committees and specifically assigned activity groups.
 - E. To review all applicants for initial appointment, reappointment, and when applicable Clinical Privileges, and to make recommendations to the Hospital Board of Directors regarding the same.
 - F. To fulfill the Medical Staff's accountability to the Hospital Board of Directors for the oversight of the quality of medical care provided to patients.
 - G. To take all reasonable steps to ensure the professional and ethical conduct as well as the competent clinical performance of all members of the Medical Staff. This shall include the initiation of Medical Staff peer review action when warranted in accordance with the Medical Staff Bylaws.
 - H. To lead the Medical Staff in collaboration with the Hospital's performance improvement activities and their implementation.
 - I. To be responsible for Medical Staff compliance with the Indiana State Department of Health regulations and the accreditation standards of the Joint Commission.
 - J. To keep the Medical Staff apprised of Medical Executive Committee activities on an ongoing basis.
 - K. To take reasonable steps to develop continuing education activities and programs for the Medical Staff.
 - L. To recommend action to the Hospital President and the Hospital Board of Directors on hospital management matters including but not limited to long range planning and contracts for patient care services.

Section 2. Multidisciplinary Committees

The Medical Staff shall develop multidisciplinary Committees for designated purposes to assist in quality assessment and performance improvement activities. The President of the Medical Staff shall appoint the chair and all the members of these committees. Each committee will document its purpose and responsibilities in Policies that are attendant to these By-Laws. Each committee shall maintain a record of its proceedings and shall forward reports and recommendations to The Medical Executive Committee for final action. A listing of these committees includes, but is not limited to the:

- A. Administrative Committee
- B. Clinical Committee
- C. Quality Resource Management Committee

Section 3. The Physicians Assistance Committee

The Physicians Assistance and Advocacy Committee shall meet as often as needed to address any potential or confirmed physician impairment issues identified. This committee will provide a forum for assistance, advocacy, monitoring, education, consultation,

intervention, and shall recommend policies related to physician impairment. This committee's activities shall remain separate from any disciplinary or enforcement activities. The committee will take referrals from any concerned source, report findings, and make recommendations to the Medical Executive Committee as indicated.

Section 4. Special Committees

Special Committees may be appointed by the President of the Medical Staff to carry out a specific function of the Medical Staff. These committees will confine their work to the purpose for which they were appointed and shall make a report to the Executive Committee. When the specific function has been completed, the special committee will be dissolved.

Section 5. Quorum

Unless otherwise indicated, those physician members present shall constitute a quorum for all Medical Staff Multidisciplinary Committees, the Physicians Assistance and Advocacy Committee, and any Special Committees described in Section 5 of this Article.

Section 6. Clinical Advisors

The President of the Medical Staff, in collaboration with the Hospital Administration, shall annually appoint advisors for the various patient care areas of the Hospital where on-going or periodic assistance of a clinical nature may be required. Clinical Advisors may be selected from the Active or Affiliate categories of the Medical Staff. A Medical Staff Member may be Clinical Advisor in more than one patient care area if appropriate. Each Clinical Advisor shall be qualified by training, experience, and demonstrated ability in the patient care area assigned.

The general functions of the Clinical Advisor shall be to:

- A. Review Medical Staff Rules, Regulations, Policies and Procedures as they pertain to their patient care area and recommend revisions to the Clinical Committee when appropriate.
- B. Advise the Medical Executive Committee regarding requests for Clinical Privileges by a Practitioner.
- C. Make Recommendation to the Medical Executive Committee of criteria for granting Clinical Privileges to assure patients will receive quality care.
- D. Collaborate with the Hospital on the identification of performance improvement activities and their implementation.
- E. Provide the Hospital managers, nurses, and ancillary staff advice and assistance on clinical matters pertinent to their patient care area.
- F. Advise the Quality Resource Management Committee when any Staff Member does not meet the standard of care demanded by the Medical Staff and Hospital Board of Directors.

ARTICLE IX: THE SINGLE, UNIFIED, INTEGRATED MEDICAL STAFF

Upon approval of the Parkview LaGrange Board of Directors and affirmative vote of two-thirds of the Active Medical Staff, the Medical Staff at Parkview LaGrange Hospital may elect to join the Medical Staff(s) of any or all other Hospitals affiliated with Parkview Health System, Inc., to form a single, unified, integrated medical staff. In order to call for a vote to “opt in” to a single Medical Staff, at least three (3) members of the Active Medical Staff must submit a request for a vote to the President of the Medical Staff. Notice of the request for a vote shall be sent to all Active Medical Staff Members no less than four (4) weeks or more than eight (8) weeks before the vote shall be held. The vote shall be by written ballot. The vote shall be held at a regularly scheduled Medical Staff meeting or at a special meeting at the discretion of the Medical Staff President. Active Medical Staff Members may hand deliver their vote to the Medical Staff Coordinator prior to the meeting if they are unable to attend. Should the Active Medical Staff vote affirm the desire to become part of a single Medical Staff, Policies, Rules, and Bylaws shall be developed for the single Medical Staff and said Policies, Rules, and Bylaws shall reflect the unique needs of each Hospital member. Should the Active Medical Staff vote not favor becoming part of a single Medical Staff, a new vote shall not be taken for at least one year and that vote shall likewise only be taken upon request of three (3) or more Active Medical Staff members. Should the Medical Staff elect to become part of a single Medical Staff but at a later date wish to “opt out” of that relationship, upon request of three (3) Active Medical Staff members with Privileges at Parkview LaGrange a vote to “opt out” of the single Medical Staff shall be taken. Once again, a vote of two-thirds of the Parkview LaGrange Hospital Active Medical Staff Members shall be required to “opt out”. If the Medical Staff does not elect to opt out, a repeat vote cannot be requested for at least one year.

ARTICLE X: SPECIAL MEDICAL STAFF MEETINGS

Special meetings of the Medical Staff may be called by any Medical Staff Officer or upon written request from five (5) Active Staff members. Notification as to the time, place, and reason for the meeting(s) will be communicated in writing to all members of the Active Staff at least four (4) days prior to the meeting(s). Only the designated special business will be conducted at this meeting. A permanent record of the proceedings and actions shall be maintained. A quorum will exist when fifty percent (50%) of Active Medical Staff Members are present.

ARTICLE XI: PRIVILEGE AND IMMUNITY/CONFIDENTIALITY

Section 1. Privilege and Immunity

The Medical Staff, its members, officers, and committees, along with third parties who supply information to the foregoing, shall be afforded all of the privileges and immunities provided by applicable State and Federal laws. Such immunity shall apply to all acts,

communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institutions' activities related, but not limited to:

- A. Application for appointment or Clinical Privileges
- B. Periodic reappraisals for reappointment or Clinical Privileges
- C. Corrective action, including Precautionary Suspension
- D. Hearings and appellate reviews
- E. Quality assessment activities (peer review)
- F. Utilization reviews
- G. Other activities related to Professional conduct

Section 2. Confidentiality

Inasmuch as effective peer review must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff Committees, except in conjunction with a peer review communication with other hospitals, professional societies, or licensing authorities is outside of the appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the hospital. If it is deemed that such a breach has occurred, the Medical Executive Committee may undertake such peer review action as it deems appropriate.

ARTICLE XII: HISTORY AND PHYSICALS

A History and Physical is required for all inpatient admissions, observation patients, and outpatients undergoing invasive procedures. The History and Physical must be completed within 24 hours after admission and before any invasive procedure is performed. A History and Physical performed and documented up to 30 days prior to an admission, readmission, or procedure may be used for that admission, readmission or procedure provided there is an examination and update performed within 24 hours after the admission, or readmission, and prior to any procedure documenting any significant changes. If there are no significant changes, there must be a notation on the original document, in the progress notes, or on a form specifically designed to document an H&P update so stating.

An Oral Surgeon, Dentist, or Podiatrist shall be responsible only for the history and examination pertinent to their area of specialty. The complete History and Physical shall include the following elements:

- A. History; Current (home) medications per the medication reconciliation process; Chief complaint; present illness; relevant past, social, and family history; allergies; review of systems
- B. Examination: General appearance; vital signs; head, eyes, ears, nose, and throat; chest; heart; abdomen; genitourinary; extremities; skin; neurological
- C. Diagnostic impression
- D. Treatment plan

Complete details regarding the History and Physical can be found in the Medical Staff Rules and Regulations in the Article covering the Medical Record.

ARTICLE XIII: RULES AND REGULATIONS, MEDICAL STAFF POLICIES

The Medical Staff shall initiate and adopt such Rules, Regulations, and Policies as may be necessary for the proper conduct of its work and to implement more specifically the general principles found within these Bylaws. Such Rules, Regulations, and Policies shall be subject to the approval of the Medical Executive Committee and the Hospital Board of Directors and shall be attendant to these Bylaws. Said Rules, Regulations, and Policies shall relate to the proper conduct of Medical Staff activities, and the level of practice that is to be required of each Practitioner in the Hospital. Applicants and members of the Medical Staff shall be governed by such Rules, Regulations, and Policies as are properly initiated and adopted. If there is a conflict between the Bylaws and Rules and Regulations, the Bylaws shall prevail.

ARTICLE XIV: DUES AND ASSESSMENTS

The Medical Staff has the authority to levy dues and assessments as described in Medical Staff policy.

ARTICLE XV: BYLAWS AMENDMENTS/REVISIONS

Upon recommendation of the Administrative Committee, the Medical Executive Committee, or the President of the Medical Staff these Bylaws may be amended and/or revised in the following manner.

- A. Proposed amendments or revisions to the Bylaws shall be distributed to the Active Members of the Medical Staff by mail, fax, or hand carried.
- B. Action on such proposed amendments or revisions shall be carried out at the next Medical Staff meeting which shall be not less than fourteen (14) days after the amended document distribution.
- C. Amendment or revision requires a two-thirds (2/3) majority vote of the Active Medical Staff, voting in person or by authenticated written ballot
- D. Amendments so made shall be effective when approved by the Hospital Board of Directors.

The Medical Staff and the Hospital Board of Directors acknowledge and agree that neither party may unilaterally amend these Bylaws or the Rules, Regulations, and Policies, which are attendant to these Bylaws. These Bylaws, when approved by the Medical Staff and the Hospital Board of Directors, shall replace any previous Bylaws and be equally binding for both parties. A full review of the Bylaws shall be accomplished every three (3) years.

Adopted by the Active Medical Staff of Parkview LaGrange Hospital, LaGrange, Indiana.

President of Medical Staff

4/04/17_____

Date

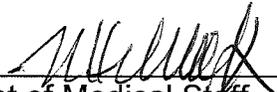
Approved by the Board of Directors of Parkview LaGrange Hospital, LaGrange, Indiana

Chair, Hospital Board of Directors

04/28/17_____

Date

Adopted by the Active Medical Staff of Parkview LaGrange Hospital, LaGrange, Indiana.



President of Medical Staff

4/04/17 _____
Date

Approved by the Board of Directors of Parkview LaGrange Hospital, LaGrange, Indiana



Chair, Hospital Board of Directors

04/28/17 _____
Date