MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF INDIANA UNIVERSITY HEALTH ACADEMIC HEALTH CENTER

MEDICAL STAFF BYLAWS

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function under these Bylaws is to be carried out by a member of Hospital administration, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. The delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee is a record of the committee that is ultimately responsible for the review in a particular matter.

(2) When a Medical Staff Leader is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the MSEC and may vary by category.

(2) Dues shall be payable annually upon request in accordance with Hospital Policy.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentials Policy are eligible to apply for appointment to one of the following categories:

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of members who:

(a) have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and Hospital through service on committees and/or active participation in performance improvement or professional practice evaluation functions; and

(b) are involved in the minimum number of patient contacts (24) per appointment term. For purposes of this Article, a "patient contact" means any direct interaction between a physician and a patient in the Hospital setting (including outpatient areas that are included in the Hospital licensure), excluding any diagnostic outpatient orders and specifically including performance of History and Physicals, diagnosis, treatment, and interpretation of diagnostic studies.

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2.A.2. Prerogatives:

Active Staff members:

(a) may vote in all general and special meetings of the Medical Staff, and applicable Department and committee meetings; and

(b) may hold office, serve as Department chiefs or co-chiefs and serve on committees.

2.A.3. Responsibilities:

Active Staff members must:

(a) assume all the responsibilities of membership on the Active Medical Staff, including committee service, emergency call, care for unassigned patients and

evaluation of members during the provisional period. The Department may determine how these responsibilities will be met.;

(b) actively participate in the peer review and performance improvement process;

(c) accept consultations when requested;

(d) attend applicable meetings;

(e) pay application fees, dues and assessments; and

(f) perform assigned duties.

2.B. AFFILIATE STAFF

2.B.1. Qualifications:

(a) The Affiliate Staff shall consist of those members who desire to be associated with, but who do not intend to establish a practice at, this Hospital. The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care.

(b) Individuals requesting appointment to the Affiliate Staff must submit an application as prescribed in the Credentials Policy.

2.B.2. Prerogatives and Responsibilities:

Affiliate Staff members:

(a) may visit their hospitalized patients and review their Hospital medical records but may not admit patients, attend patients, or exercise any clinical privileges. They may write orders or progress notes, and make notations in the medical record, in conjunction with the attending or consulting physician who has primary management of care of the patient in the Hospital;

(b) may attend educational activities of the Medical Staff and the Hospital;

(c) may serve as a Department chief or co-chief;

(d) may not vote (except for those members serving as Department chief or co-chief), hold office, or serve on Medical Staff committees;

(e) may use the Hospital's diagnostic facilities; and

(f) must pay application fees, dues and assessments.

2.C. ASSOCIATE STAFF

2.C.1. Qualifications:

The Associate Staff shall consist of practitioners of demonstrated competence qualified for staff appointment, who have an Active Staff appointment at another hospital, who:

(a) may be members of a group, which provides periodic coverage for a practitioner who is an Active Staff member in good standing at the Hospital; or

(b) are office/ambulatory-based practitioners who may have fewer than 24 patient contacts in a reappointment term.

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Associate Staff members must provide evidence of clinical performance at their primary hospital or other primary practice setting, in such form as may be requested, at each reappointment time.

2.C.2. Prerogatives and Responsibilities:

Associate Staff members:

(a) may attend educational activities of the Medical Staff and the Hospital;

(b) may not vote, hold office, serve as a Department chief or co-chief or serve on Medical Staff committees;

(c) may use the Hospital's diagnostic facilities; and

(d) must pay application fees, dues and assessments.

2.D. MOONLIGHTING STAFF

2.D.1. Qualifications:

(a) The Moonlighting Staff shall include physicians who are currently enrolled in good standing in an Accreditation Council for Graduate Medical Education ("ACGME") or American Osteopathic Association ("AOA") accredited residency or fellowship program.

(b) Individuals requesting appointment to the Moonlighting Staff must submit an application as prescribed by the Credentials Policy and must meet all of the qualifications for Medical Staff appointment outlined in Section 2.A.1 of the

Medical Staff Credentials Policy, except for those requirements relating to residency completion and board certification.

2.D.2. Prerogatives and Responsibilities:

Moonlighting Staff members:

(a) may not admit patients to the Hospital;

(b) may exercise such clinical privileges as are granted;

(c) may attend staff and Department meetings when invited to do so (without vote);

(d) may attend educational activities of the Medical Staff and the Hospital;

(e) may not vote, hold office, serve as a Department chief or co-chief or serve on Medical Staff committees;

(f) must cooperate in the peer review and performance improvement process; and

(g) shall pay application fees, dues, and assessments.

2. E. HONORARY STAFF

2.E 1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who are recognized for outstanding or noteworthy contributions to the medical sciences, or have a record of previous long-standing service to the Hospital, and have retired from the active practice of medicine.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application.

2. E.2. Prerogatives and Responsibilities:

Honorary Staff members may:

(a) not consult, admit or attend to patients;

(b) attend staff and Department meetings when invited to do so (without vote);

(c) be appointed to committees (with vote);

(d) not vote, hold office, serve as aDepartment chief or co-chief; and

(e) not pay application fees, dues or assessments.

2. F. ALLIED HEALTH STAFF

2. F.1. Qualifications:

The Allied Health Staff consists of allied health practitioners who satisfy the qualifications and conditions for appointment to the Allied Health Staff contained in the Credentials Policy. The Allied Health Staff is not a category of the Medical Staff, but is included in this Article for convenient reference. For ease of use, any reference in these Bylaws or associated policies to "members" shall include allied health practitioners unless specifically limited to members of the Medical Staff.

2. F.2. Prerogatives and Responsibilities:

Allied Health Staff members:

(a) may attend applicable Department meetings (without vote);

(b) may not hold office or serve as a Department chief or co-chief or as committee Chairs;

(c) may serve on a committee, if requested (with vote);

(d) must cooperate in the peer review and performance improvement process; and

(e) must pay applicable fees, dues, and assessments.

ARTICLE 3

OFFICERS

3.A. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

(1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least five years;

(2) have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

(3) not presently be serving as Medical Staff officers, Board members or department chairs at any other hospital and shall not so serve during their terms of office;

(4) be willing to faithfully discharge the duties and responsibilities of the position;

(5) have experience in a leadership position, or other involvement in performance improvement functions for at least two years;

(6) attend at least annually continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;

(7) have demonstrated an ability to work well with others; and

(8) not have any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

(9) not hold a position as a Department Chair of the IU School of Medicine.

3.B. DUTIES

3.B.1. President of the Medical Staff:

The President of the Medical Staff shall:

(a) act in coordination and cooperation with Hospital management in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies and needs, and report on the activities of the Medical Staff to the CEO, the CMO, and the Board;

(c) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MSEC;

(d) chair the MSEC (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio*, without vote;

(e) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the Policies and Procedures of the Hospital;

(f) appoint the members of the Nominating Committee;

(g) recommend Medical Staff representatives to Hospital committees; and

(h) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy.

3.B.2. Vice President:

The Vice President shall:

(a) assume all duties of the President of the Medical Staff and act with full authority as President of the Medical Staff in his or her absence;

(b) serve on the MSEC; and

(c) assume all such additional duties as are assigned to him or her by the President of the Medical Staff or the MSEC.

3.B.3. Immediate Past President of the Medical Staff:

The Immediate Past President of the Medical Staff shall:

(a) serve on the MSEC;

(b) serve as an advisor to other Medical Staff leaders; and

(c) assume all duties assigned by the President of the Medical Staff or the MSEC.

3.B.4. Secretary:

The Secretary shall:

(a) serve on the MSEC;

(b) cause to be kept accurate and complete minutes of all MSEC and Medical Staff meetings;

(c) call Medical Staff meetings on order of the President of the Medical Staff and record attendance; and

(d) attend to all correspondence and perform such other duties as ordinarily pertain to the office of Secretary.

3.B.5. Treasurer:

The Treasurer shall:

(a) serve on the MSEC; and

(b) collect staff dues and make disbursements authorized by the MSEC or its designees.

3.C. NOMINATIONS

A Nominating Committee selected by the President of the Medical Staff shall be convened at least 45 days prior to the election. The Nominating Committee shall submit to the President of the Medical Staff the names of one or more qualified nominees for each office and any at-large members of the MSEC. Notice of the nominees shall be provided to the Medical Staff prior to the election. Nominations may also be submitted in writing by petition signed by at least five Active Staff members at least ten days prior to the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.A, in the judgment of the Nominating Committee, and be willing to serve. Nominations from the floor shall not be accepted.

3.D. ELECTION

(1) If the Nominating Committee presents a single nomination for any office or at-large position and there are no other nominees presented by other means, the unopposed candidates shall be deemed to be elected and no vote is necessary.

(2) Where there are two or more nominees for any office or at-large position, the election shall be held by written or electronic ballot returned to the Medical Staff Office. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Medical Staff Office by the date indicated on the ballot. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role.

(3) In the alternative, and in the discretion of the MSEC, an election may also occur at a called meeting of the Medical Staff. Candidates receiving a majority of votes cast at the meeting shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

3.E. TERM OF OFFICE

Officers shall serve for a term of one year or until a successor is elected.

3.F. REMOVAL

(1) A vote by the MSEC to remove an elected officer or any member of the MSEC may be initiated by a two-thirds vote of the MSEC, a two-thirds vote of the Active Staff, or by the Board. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to perform the duties of the position held;

(c) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(d) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) The individual shall be given 10 days' written notice of the date of the MSEC meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MSEC at this meeting prior to the vote on removal.

3.G. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the Vice President, who shall serve until the end of the President's unexpired term. In the event there is a vacancy in another office, the MSEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, in the discretion of the MSEC.

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

The Medical Staff shall be organized into Departments as listed in the Organization Manual. Each Department of the Medical Staff corresponds to a Department of the Indiana University School of Medicine and is directed by the Department Chief who will be the Department Chair or his/her designate. Subject to the approval of the Board, the MSEC may create new organizational units including but not limited to Institutes, Centers of Excellence or others.

4.B. ASSIGNMENT TO DEPARTMENT

(1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical Department. Assignment to a particular Department does not preclude an individual from seeking and being granted clinical privileges typically associated with another Department.

(2) An individual may request a change in Department assignment to reflect a change in the individual's School of Medicine Department.

4.C. FUNCTIONS OF DEPARTMENTS

The Departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the Departments, and (ii) to monitor the practice of all those with clinical privileges in a given Department. Each Department shall assure emergency call coverage for all patients.

4.D. QUALIFICATIONS OF DEPARTMENT CHIEFS AND CO-CHIEFS

The Department chief or co-chiefs shall:

(1) be a member of the Active or Affiliate Staff;

(2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and

(3) satisfy eligibility criteria (2) through (8) in Section 3.A.

4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHIEFS AND CO-CHIEFS

(1) Except as otherwise provided by contract, Department chiefs and co-chiefs shall be elected by theappointed by Indiana University School of Medicine and Indiana University Health.

(2) A vote by the MSEC to remove a Department chief or co-chief may be initiated by a two-thirds vote of the Department, a two-thirds vote of the, or by the Board. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to perform the duties of the position held;

(c) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(d) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(3) The individual shall be given 10 days' written notice of the date of the MSEC meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MSEC at this meeting prior to a vote on removal.

(4) Department chiefs and co-chiefs shall serve a term equal to their appointment as Department Chair or co-chief.

4.F. DUTIES OF DEPARTMENT CHIEFS AND CO-CHIEFS

Department chiefs and co-chiefs shall work in collaboration with Medical Staff Leaders and other Hospital personnel to collectively be responsible for the following:

(1) reviewing and reporting on applications for initial appointment and clinical privileges, including interviewing applicants;

(2) reviewing and reporting on applications for reappointment and renewal of clinical privileges;

(3) evaluation of individuals during the provisional period;

(4) participation in the development of criteria for clinical privileges;

(5) reviewing and reporting on the professional performance of individuals practicing within the Department;

(6) all clinically-related activities of the Department;

(7) all administratively-related activities of the Department, unless otherwise provided for by the Hospital;

(8) continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges;

(9) recommending criteria for clinical privileges that are relevant to the care provided in the Department;

(10) evaluating requests for clinical privileges for each member of the Department;

(11) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the Department or the Hospital;

(12) the integration of the Department into the primary functions of the Hospital;

(13) the coordination and integration of interdepartment and intradepartment services;

(14) the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

(15) recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(16) determination of the qualifications and competence of Department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(17) continuous assessment and improvement of the quality of care, treatment, and services provided;

(18) maintenance of quality monitoring programs, as appropriate;

(19) the orientation and continuing education of all persons in the Department;

(20) recommendations for space and other resources needed by the Department; and

(21) delegation to a vice chief such duties as appropriate, including, but not limited to, the review of applications for appointment, reappointment, or clinical privileges or questions that may arise if the Department chief or co-chief has a conflict of interest with the individual under review.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. MSEC

5.A.1. Composition:

(a) The MSEC shall include as voting members:

- the officers of the Medical Staff (President of the Medical Staff, Vice President, Immediate Past President of the Medical Staff, Secretary, and Treasurer);
- the co Chairs of the Credentials Committee;
- a Chair of the QPRC (in addition to the Vice President);
- a Chair of the Professional Standards Committee;
- standing members include the Indiana University School of Medicne Department chairs of Medicine, Surgery and Pediatrics
- four at large Department Chairs
- five other members of the Medical Staff elected at-large who are broadly representative of the following clinical specialty areas: pediatrics, surgery, medicine, primary care, and the Hospital-based services.

At-large members and at large Department Chairs shall serve for three-year, staggered terms and must be members in good standing of the Active or Affiliate Staff. These members are identified through the Nomination Committee.

(b) The following individuals shall serve as *ex officio* members of the MSEC, without vote:

- adult and pediatric facility CEO;
- adult and pediatric facility COO as needed;
- the adult and pediatric facility Chief Nursing Officers;
- the facility-based CMOs;
- a facility-based CMIO; and
- representative from house staff forum

- other administrative representatives who may be invited to attend a particular meeting (as guests, without vote) in order to assist the MSEC in its discussions and deliberations regarding the issues on its agenda.

Ex-officio members may be excused from the voting portion of the meeting involving a recommendation which may adversely affect a physician's continued medical staff membership and/or clinical privilges or at the discretion of the presiding officer

(c) The President of the Medical Staff will chair the MSEC.

5.A.2. Duties:

The MSEC is delegated the primary authority over activities related to the functions of the Medical Staff and to performance improvement activities. This authority may be removed or modified by amending these Bylaws and related policies. The MSEC is responsible for the following:

(a) recommending directly to the Board on at least the following:

(1) the structure of the Medical Staff;

(2) the process used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment and reappointment;

(4) a delineation of clinical privileges for each eligible individual;

(5) the participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the process by which Medical Staff appointment may be terminated;

(7) hearing procedures;

(8) reports and recommendations from Medical Staff committees, Departments , and other groups, as appropriate;

(9) quality indicators to promote uniformity regarding patient care services;

(10) activities related to patient safety; and

(11) the process of analyzing and improving patient satisfaction;

(b) consulting with administration on quality-related aspects of contracts for patient care services;

(c) providing oversight and guidance with respect to continuing medical education activities;

(d) reviewing or delegating the review of quality indicators to facilitate uniformity regarding patient care services;

(e) providing leadership in activities related to patient safety;

(f) providing oversight in the process of analyzing and improving patient satisfaction;

(g) providing and promoting effective liaison among the Medical Staff, Administration, and the Board;

(h) reviewing, or delegating to the Bylaws Committee the responsibility to review, at least every three years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable;

(i) performing any other functions as are assigned to it by these Bylaws, the Credentials Policy, or other applicable policies; and

(j) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the Officers are empowered to act in urgent situations between MSEC meetings).

5.A.3. Meetings:

The MSEC shall meet as often as necessary to fulfill its responsibilities and maintain a permanent record of its proceedings and actions.

5.B. PERFORMANCE IMPROVEMENT FUNCTIONS

The Medical Staff leadership is actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

(1) patient safety, including processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;

(2) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(3) medical assessment and treatment of patients;

(4) the use of information about adverse privileging determinations regarding any practitioner;

(5) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(6) the utilization of blood and blood components, including review of significant transfusion reactions;

(7) operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(8) appropriateness of clinical practice patterns;

(9) significant departures from established patterns of clinical practice;

(10) education of patients and families;

(11) coordination of care, treatment and services with other practitioners and Hospital personnel;

(12) accurate, timely and legible completion of medical records;

(13) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix A of these Bylaws;

(14) the use of developed criteria for autopsies;

(15) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(16) nosocomial infections and the potential for infection;

(17) unnecessary procedures or treatment; and

(18) appropriate resource utilization.

5.C. CREDENTIALING AND PEER REVIEW FUNCTIONS

Mechanisms for appointment, reappointment, delineation of clinical privileges, collegial and educational efforts, investigations, hearings and appeals that apply to Medical Staff members shall be contained in the Credentials Policy.

5.D. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) All committee chairs and members shall be appointed by the President of the Medical Staff. Committee chairs shall be selected based on the criteria set forth in Section 3.A of these Bylaws.

(2) Committee chairs and members shall be appointed for initial terms of one year, but may be reappointed for additional terms.

(3) Allied Health Staff members may also be appointed to serve as voting members of Medical Staff Committees.

(4) The President of the Medical Staff and the CEO (or their respective designees) shall be members, *ex officio*, without vote, on all committees, unless otherwise stated.

5.E. CREATION OF STANDING COMMITTEES

In accordance with the provisions in the Organization Manual, the MSEC may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the MSEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force shall be performed by the MSEC.

5.F. SPECIAL TASK FORCES

Special task forces shall be created and their members and ~~chairmen~~chairs shall be appointed by the President of the Medical Staff. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the MSEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least once a year.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MSEC, the Board, or by a petition signed by not less than 25% of the Active Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each Department and committee shall meet as often as necessary to fulfill its responsibilities, at times set by the presiding officer.

6.C.2. Special Meetings:

A special meeting of any Department or committee may be called by or at the request of the presiding officer, the President of the Medical Staff, or by a petition signed by not less than one-fourth of the Active Staff members of the Department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of Department and committees in a reasonable time frame in advance of the meetings. All notices shall state the date, time, and place of the meetings.

(b) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, Department, or committee, those voting members present (but not fewer than two) shall constitute a quorum. Exceptions to this general rule are as follows:

(1) for amendments to the Medical Staff Bylaws, at least 25% of the Active Staff shall constitute a quorum; and

(2) that for meetings of the MSEC and the Credentials Committee, the presence of at least 50% of the voting members of the committee shall constitute a quorum.

(b) Once a quorum is established, the business of the meeting may continue and actions taken will be binding, even if attendance drops below a quorum during the course of the meeting.

(c) Recommendations and actions of the Medical Staff, Departments, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

(d) When determining whether a specific percentage or a majority has been achieved with respect to a vote of the Medical Staff, a Department, or a committee, an individual who has recused himself or herself from participation in the vote shall not be counted as a voting member (for example, if there are ten voting members of a committee and one recuses himself or herself on a particular matter, the majority vote for that matter would be calculated as five of the remaining nine votes).

(e) As an alternative to a formal meeting, and at the discretion of the presiding officer, the voting members of the Medical Staff, a Department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, website posting, or telephone, or other technology approved by the presiding officer, and their votes returned by the method designated in the notice. Except as noted in (a) above, a quorum for purposes of these votes shall be the number of responses returned to the presiding officer by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

6.D.3. Agenda:

The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, Department, or committee.

6.D.4. Rules of Order:

Robert's Rules of Order shall not be binding at Medical Staff meetings or elections, but may be used for reference in the discretion of the presiding officer for the meeting. Rather, specific provisions of these Bylaws, and Medical Staff Department or committee custom shall prevail at all meetings, and the Department chief or co-chiefs or Committee Chair shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, Departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.

(b) A summary of all recommendations and actions of the Medical Staff, Departments, and committees shall be transmitted to the MSEC, CEO, and CMO. The Board shall be kept apprised of the recommendations of the Medical Staff and itsDepartments and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

All Medical Staff business conducted by committees or Departments is considered confidential and proprietary and should be treated as such. Members of the Medical Staff who have access to, or are the ~~subjects~~subject of, credentialing and/or peer review information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the-Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MSEC and the Credentials Committee is required. All members are required to attend at least 50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) Each Active Staff member is expected to attend and participate in all Medical Staff meetings and applicableDepartment and committee meetings each year.

ARTICLE 7

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy.

7.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials Policy.

7.B. PROCESS FOR CREDENTIALING (APPOINTMENT, AND REAPPOINTMENT)

(1) Complete applications are provided to the applicable Department chief or co-chiefs, who reviews the individual's education, training, and experience and prepares a report on whether the individual meets all qualifications. This report will be forwarded to the Credentials Committee.

(2) The Credentials Committee then reviews the Department chief or co-chiefs' report, the application, and all supporting materials and makes a recommendation to the MSEC. The recommendation of the Credentials Committee will be forwarded, along with the Department chief or co-chiefs' report, to the MSEC for review and recommendations.

(3) The MSEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MSEC is to grant appointment or reappointment, it will be forwarded to the Board for final action. If the recommendation of the MSEC is unfavorable, the individual will be notified by the CEO of the right to request a hearing.

7.C. PROCESS FOR PRIVILEGING

(1) Requests for privileges are provided to the applicable Department chief or co-chiefs, who reviews the individual's education, training, and experience and prepares a report on whether the individual meets all qualifications. This report will be forwarded to the Credentials Committee.

(2) The Credentials Committee will review the Department chief or co-chiefs' report, the application, and all supporting materials and make a recommendation. The recommendation of the Credentials Committee will be forwarded, along with the Department chief or co-chiefs' report, to the MSEC for review and recommendations.

(3) The MSEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MSEC is to grant privileges, it will be forwarded to the Board for final action. If the recommendation of the MSEC is unfavorable, the individual will be notified by the CEO of the right to request a hearing.

7.D. DISASTER PRIVILEGING

When the disaster plan has been implemented, the CEO or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

7.E. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges will be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

(iv) complete and/or comply with training, educational, or orientation requirements; or

(v) attend a special conference to discuss issues or concerns;

(b) is involved or alleged to be involved in defined criminal activity;

(c) makes a misstatement or omission on an application form;

(d) remains absent on leave for longer than one year, unless an extension is granted; or

(e) in the case of an Advanced Dependent Practitioner, fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in the Credentials Policy or if the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated.

(2) Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

7.F. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the CEO, the President of the Medical Staff, the CMO, the MSEC, or the Board chair is authorized to suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the CEO or MSEC.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MSEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the MSEC or an ad hoc committee of the MSEC as designated by the President of the Medical Staff.

7.G. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an investigation, the MSEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) violation of ethical standards or the bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; or (c) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

7.H. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel in the form of a post-hearing statement submitted at the close of the hearing.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

(7) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(8) The affected individual and the MSEC may request an appeal of the recommendations of the Hearing Panel to the Board.

ARTICLE 8

AMENDMENTS

8.A. MEDICAL STAFF BYLAWS

(1) Neither the MSEC, the Medical Staff, nor the Board may unilaterally amend these Bylaws.

(2) Amendments to these Bylaws may be proposed by a petition signed by 25% of the members of the Active Staff, by the Bylaws Committee, or by the MSEC.

(3) In the discretion of the MSEC, amendments to the Bylaws shall be presented to the Medical Staff in one of the following two ways:

(a) Amendments Subject to Vote at a Meeting: The MSEC shall report on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 25% of the Active Staff must be present, and (ii) the amendment must receive a majority of the votes cast by the Active Staff at the meeting.

(b) Amendments Subject to Vote via Written or Electronic Ballot: The MSEC shall present proposed amendments to the Active Staff by written or electronic ballot, to be returned to the Medical Staff Office by the date as indicated on the ballot, which date shall be at least 14 days after the proposed amendment was provided to the Active Staff. Along with the proposed amendments, the MSEC, shall provide a written report on the amendments either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 25% of the Active Staff, and (ii) the amendment must receive a majority of the votes cast.

(4) The MSEC shall have the power to adopt clarification and technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, renaming of titles or positions, punctuation, spelling, or-errors in grammar or expression.

(5) All amendments shall be effective only after approval by the Board.

(6) If the Board has determined not to accept a recommendation submitted to it by the MSEC or the Medical Staff, the MSEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall

be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

8.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that are applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and rules and regulations shall be considered an integral part of the Medical Staff Bylaws, but amended in accordance with this Section.

(2) An amendment to the Credentials Policy, Medical Staff Organization Manual, or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MSEC present and voting at any meeting of that Committee where a quorum exists. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the MSEC meeting when the vote is to take place. Any member of the Active Staff may submit written comments on the amendments to the MSEC.

(3) All other policies of the Medical Staff may be adopted and amended by a majority vote of the MSEC. No prior notice is required.

(4) Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by at least 25% of themembers of the Active Staff. Any such proposed amendments will be reviewed by the MSEC, which may comment on the amendments before they are forwarded to the Board for its final action.

(5) Adoption of and changes to the Credentials Policy, Medical Staff Organization Manual, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

8.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MSEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations,

(b) a new policy proposed or adopted by the MSEC, or

(c) proposed amendments to an existing policy that is under the authority of the MSEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by at least 25% of the members of the Active Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to.

(2) If the differences cannot be resolved at the meeting, the MSEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the Active Staff members, to the Board for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the CEO, who will forward the request for communication to the Chair of the Board. The CEO will also provide notification to the MSEC by informing the President of the Medical Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

ARTICLE 9

INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, Department chiefs and co-chiefs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Hospital's bylaws.

ARTICLE 10

ADOPTION

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof.

Originally adopted by the Medical Staff on February 15, 2011 and approved by the Board on February 24, 2011.

Revisions by the Medical Staff on December 4, 2012
Approved by the Board on December 13, 2012

Revisions by the Medical Staff on November 16, 2015
Approved by the Board on December 17, 2015

Revisions by the Medical Staff on September 17, 2018
Approved by the Board on December 13, 2018

Revisions by the Medical Staff on September 15, 2020
Approved by the Board on October 1, 2020

APPENDIX A

HISTORY AND PHYSICAL

A complete history and physical examination must be completed within twenty-four (24) hours after admission or prior to a surgery or procedure by the attending physician/dentist or physician/dentist designee with oversight (resident, nurse practitioner). A legible original or copy of a medical history and physical obtained in the physician/dentist's office completed within thirty (30) days prior to date of admission is acceptable if the patient's clinical status information is updated within twenty-four (24) hours after admission or prior to a surgery or procedure if occurring within the first twenty-four (24) hours. In an emergency situation, the responsible physician/dentist must make a comprehensive entry regarding the condition of the patient prior to the start of the procedure. A complete history and physical examination is then to be recorded immediately following the emergency procedure. A comprehensive history and physical examination report is to include the chief complaint, details of the present illness, all relevant past medical, social and family histories, inventory of body systems, current physical examination, allergies / medications / dosage / reactions, conclusions, and plan of action. For further details, please reference IU Health AHC Medical Staff Policy on Completion of Medical Records and IU Health AHC Administrative Policy on Content of Medical Records.