



**Indiana University Health**

**WHITE MEMORIAL HOSPITAL**

**MEDICAL STAFF**

**BYLAWS**

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# **BYLAWS OF THE MEDICAL STAFF INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL**

## **PREAMBLE**

**WHEREAS**, Indiana University White Memorial Hospital (“Hospital”) is a nonprofit acute care hospital organized under the laws of the State of Indiana and located in Monticello, Indiana; and

**WHEREAS**, the Hospital’s purpose is to serve as a general type of Hospital providing patient care, education, and research to the Monticello, White County and surrounding community; and

**WHEREAS**, the Hospital is organized such that the Medical Staff is delegated the initial responsibility for the quality of medical care in the Hospital and must accept and discharge this responsibility, as the agents of and subject to the ultimate authority of the Board of Directors, and that the cooperative efforts of the Medical Staff, the Administrator and Board of Directors are necessary to fulfill the Hospital's obligation to its patients; and

**WHEREAS**, the Board of Directors, the Medical Staff, and any of their committees or agents, in order to promote professional peer review activity designed to establish a harmonious environment in which appropriate standards of medical care may be achieved, constitute themselves as professional review bodies as defined in the Health Care Quality Improvement Act of 1986 and as peer review committees as defined by the Indiana Peer Review Act, IC 34-30-15 et seq., and claim all of the privileges and immunities of those acts.

**THEREFORE**, the Physicians, Dentists, and Allied Health Professionals practicing in this Hospital hereby organize their efforts in conformity with these Bylaws.

## DEFINITIONS

1. The terms "**Medical Staff**" or "**Staff**" mean all Physicians and Dentists who through formal appointment as Staff members are thereby privileged to attend patients in Indiana University Health White Memorial Hospital (IU Health White Memorial).
2. The term "**Physicians and Dentists**" includes Doctor of Medicine, osteopathy, dental surgery and medical dentistry, as covered in the Health Care Quality Improvement Act of 1986.
3. The term "**Executive Committee**" means the Medical Staff Executive Committee.
4. The term "**Administrator**" means the individual appointed by the Governing Board to act in its behalf in the overall management of the Hospital.
5. The term "**Practitioner**" means an appropriately licensed physician, dentist or allied health professional.
6. The term "**Hospital**" means Indiana University Health White Memorial Hospital.
7. The term "**Allied Health Professional**" means all individually licensed health care providers other than Physicians and Dentists who may qualify to exercise specified clinical privileges or a scope of practice within the Hospital, which includes Licensed Independent Practitioners (LIP) Allied Health Professional Staff (AHPs): Podiatrists, and Dependent Allied Health Professional Staff (AHPs): Physician Assistants, Advanced Practice Providers - Certified Nurse Specialists (CNS), Certified Registered Nurse Anesthetists (CRNA) and Nurse Practitioners (NP), Registered Nurses, Licensed Practical Nurses, and Certified Surgical Technologists (including Certified Surgical First Assistants). AHPs are governed by these Bylaws but are NOT members of the Medical Staff.
8. The term "**days**" as used in the Bylaws with respect to time allowed for delivery or receipt of Notice shall mean calendar days (i.e. including Saturdays, Sundays and holidays). If the due date for Notice falls on a weekend or holiday, the due date shall be extended to the next working day thereafter. The time limits set forth herein shall be goals subject to good faith attempts at compliance, and failure to achieve those goals shall not give rise to rights of action.
9. The term "**Board**" or "**Governing Board**" means the Board of Directors of Indiana University Health White Memorial Hospital (also known as the West Central Regional Board).
10. The term "**adversely affecting clinical privileges or membership on the Medical Staff**" or any term or phrase in derivation of this term, shall mean any action reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges of a Practitioner or membership on the Medical Staff of the Hospital. Letters of reprimand or warning requirements of proctoring or consultations, summary suspensions not in excess of fourteen (14) days, requirements of further continuing medical education or training, imposition of terms of probation which do not prevent a Practitioner from exercising any privileges which have been granted to him or her; and the review

of a Practitioner's current or previous charting practices and/or the review of the information reflected in such charts, shall not constitute adverse action and shall not give rise to right to a hearing or appeal. Further, automatic suspensions for failure to complete medical records in a timely fashion, to maintain licensure or DEA registration, to maintain professional liability insurance and to qualify as a health care provider under the Medical Malpractice Act, to complete any requirements of continuing medical education or to attend Medical Staff or committee meetings shall not be deemed "adverse action". Finally, a decision by the Hospital to enter into an exclusive contract which prevents a Practitioner from exercising their Medical Staff privileges shall not be deemed an action which adversely affects clinical privileges or membership on the Medical Staff.

11. The term "**clinical privileges**" shall mean privileges, membership on the Medical Staff, and/or other circumstances pertaining to the furnishing of medical care under which a Practitioner is permitted to furnish such care to the Hospital. "Clinical privileges" does not include assignment to categories, departments, or committees, or participation in Medical Staff functions by Allied Health Professionals. Privileges for contracted staff and individuals employed or having an agreement with a physician maintain privileges for only as long as the contract/relationship exists.
12. The term "**direct economic competition**" shall pertain to any medical practice of an individual who would with reasonable probability have a financial benefit from the outcome of any professional review action taken against a Practitioner.
13. The term "**peer review committee**" shall mean the Governing Board, any committee of the Medical Staff or Board, including a committee of the whole Medical Staff, or their designated agents having the responsibility for evaluation, recommendation or making a determination concerning qualifications of a professional health care provider or patient care rendered by a professional health care provider, or the merits of a complaint against a professional health care provider. Peer review committee functions shall include the review of competence and professional conduct of professional health care providers leading to determinations concerning the granting of privileges or Medical Staff membership, the scope and condition of such privileges or membership, and the modification of such privileges or membership.
14. The term "**personnel of a peer review committee**" means not only members of the committee, but also all of the Committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves a peer review committee in any capacity, including any person under contract or other formal agreement.
15. The term "**professional health care provider**" means a licensed Physician, Dentist, or Allied Health Professional who is a professional health care provider under Indiana law.
16. The term "**professional review action**" means an action or recommendation of a peer review committee which is taken or made in the conduct of professional review activity or peer review.
17. The term "**professional review activity or peer review activity**" includes all of the functions of a peer review committee as defined, including a formal decision of such a committee not to take an action or make a recommendation.

18. The term "**summary suspensions**" are suspensions of all or any portion of a Practitioner's clinical privileges for a period not to exceed fourteen (14) days during which an investigation is being conducted to see if any corrective action is necessary. Summary suspensions may be imposed to protect either patient safety and/or the orderly operation of the Hospital in a non-disruptive manner. If a summary suspension is lifted or terminated in fourteen (14) days or less without a further recommendation for adverse action, no right to a hearing or appeal shall arise unless a summary suspension has been imposed on the same Practitioner more than twice in any six-month period of time.
19. The term "**proctoring**" shall mean the supervision of, and recommendations and directions to, a Practitioner with respect to the diagnosis or treatment of any particular case.
20. The term "**consultation**" shall mean the Practitioner's deliberation with one or more other Practitioners with respect to the diagnosis or treatment of any particular case.
21. The term "**monitoring**" shall mean the mere observation of a Practitioner in the course of his or her diagnosis or treatment of any particular case.
22. The term "**Impaired Physician**" shall mean a Practitioner who is unable to practice medicine or dentistry with reasonable skill and safety to patients because of a physical, emotional or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol.

## **ARTICLE I - NAME**

The name of this organizational unit of Indiana University Health White Memorial Hospital shall be the Medical Staff of Indiana University Health White Memorial Hospital.

## **ARTICLE II - PURPOSE**

The purposes for which this Medical Staff is organized shall be:

- To promote appropriate standards of medical practice in the Hospital;
- To conduct peer review activity as the agents of the Board;
- To serve in an advisory capacity on Hospital projects and activities in cooperation with the Board and the Administrator;
- To conduct regular meetings and such special meetings as may be required for the following purposes:
  - a. To Review and analyze the clinical practice of the Hospital and reporting matters of scientific interest;
  - b. To consider the affairs of the Hospital bearing upon its effectiveness in serving the medical needs of the community.
- To provide continuing educational programs for all members of the Staff

### **ARTICLE III - PERSONS GOVERNED BY BYLAWS**

- A. **Persons Governed:** These Bylaws shall govern applicants for and members of the Medical Staff, and Allied Health Professional Staff.
  
- B. **Not a Contract:** These Bylaws are not a contract of any kind between the Board, and the Medical Staff, or any individual Physician, Dentist, or Allied Health Professional. The continuance of a Practitioner's privileges at this Hospital is based solely upon his or her continuing ability to justify the exercise of such privileges, and privileges do not obligate a Practitioner to practice at the Hospital.

## ARTICLE IV - STAFF MEMBERSHIP

### QUALIFICATIONS

#### A. Threshold Eligibility Criteria

To be eligible to apply for initial appointment, reappointment or clinical privileges, the applicant must, as applicable:

- (a) *Licenses*: have a current, unrestricted license to practice in Indiana as a physician or dentist; AHP shall have a current unlimited Indiana state license in their profession;
- (b) *DEA/CSR*: have a current, unrestricted DEA registration and state-controlled substance license; specialties not ordering or prescribing medications shall be exempt from this requirement (if applicable);
- (c) *Location*: be located close enough to fulfill their medical staff responsibilities and to provide timely and continuous care for their patients in the hospital;
- (d) *Malpractice coverage*: have current, valid professional liability insurance coverage (including patient compensation fund coverage) in a form and in amounts satisfactory to the Hospital and the state of Indiana;
- (e) *Fraud/Abuse*: have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;
- (f) *Exclusions*: have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care programs;
- (g) *Revocation/Termination*: have never had Medical Staff appointment, permission to practice, or clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, or termination of employment with “do not rehire” status from IU Health;
- (h) *Resignation/Investigation*: have never resigned Medical Staff appointment or permission to practice or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;
- (i) *Conviction*: have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence (i.e. *Criminal activity felony* – arrest, indictment, conviction, or plea of guilty or no contest to ANY felony; *Criminal activity misdemeanor* – convicted or enters plea of guilty or no contest to any misdemeanor involving controlled substances, illegal drugs, Medicare/Medicaid, insurance or healthcare fraud or abuse, or violence);
- (j) *Demonstration of clinical activity*: demonstrate recent clinical activity in their primary area of practice during at least two of the last four years;
- (k) *Dependent - AHP written agreement*: the exercise of these clinical privileges requires a designated collaborating/supervising physician with clinical privileges at the hospital in the same area of specialty practice. All practice is performed in accordance with the written agreement and policies and protocols approved by the MEC, nursing administration and the governing body. A copy of the written agreement signed by both parties is to be provided for the credentials file;

- (l) *Education/Training*: have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education (“ACGME”) or the American Osteopathic Association (“AOA”) in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association (“ADA”), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association may apply as an Independent AHP.
- (m) *Board certification*: be board certified in their primary area of practice at the Hospital and maintain such certification throughout the period of appointment unless one of the following exceptions apply:
- (1) Initial applicants who are not board certified at the time of application but who will/have completed their residency or fellowship training within five (5) years shall be eligible for Medical Staff appointment and shall obtain certification within 5 years of appointment;
  - (2) Board certification in another country that may be considered equivalent to the American boards shall be evaluated on a case-by-case basis;
  - (3) Applicant’s initial application date is on or prior to July 1, 2018 and at that time was not board certified but was widely recognized as having skills that meet the standards for membership on the Medical Staff.
- (n) *Maintenance of board certification*: maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification shall be assessed at reappointment.  
The requirements for board certification and maintenance of board certification shall be applicable only to those individuals who apply for initial staff appointment after the date of adoption of these criteria (date stated above). Existing members shall be governed by the residency training and board certification requirements in effect at the time of their initial appointment (grandfathered).
- (o) *Health Status*: An applicant submits a statement that no physical, mental, or emotional health problems exist that could affect his or her ability to perform the privileges requested. The applicant's ability to perform privileges requested must be evaluated. This evaluation is documented in the individual's credentials file. Such documentation may include the applicant's statement that no health problems exist that could affect his or her practice. Documentation regarding an applicant’s health status and his or her ability to practice should be confirmed. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital or critical access hospital at which the applicant holds privileges, or by a currently licensed doctor of medicine or osteopathy approved by the medical staff. In instances where there is doubt about an applicant’s ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff.
- (p) *Conduct*: Ability to work with others in a cooperative professional manner in the provision of patient care.

**B. Waiver of Threshold Eligibility Criteria**

- (a) Waivers of threshold eligibility criteria shall not be granted routinely. No one is entitled to a waiver. An application from an applicant who does not meet the threshold criteria for appointment, reappointment, or clinical privileges shall not be processed unless the Board Committee on Quality and Safety (BCQS) has granted the requested waiver.
- (b) A request for a waiver shall only be considered if the applicant provides information sufficient to demonstrate that his/her qualifications are equivalent to or exceed the criterion in question and that there are exceptional circumstances that warrant a waiver.
- (c) The Credentials Committee may consider supporting documentation submitted by the applicant, any relevant information from third parties, input from the relevant liaisons, and the best interests of the Hospital and the communities it serves. The Credentials Committee shall forward its recommendation, including the basis for such, to the MEC.
- (d) The MEC shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.

The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment shall be granted; only that processing of the application can begin.

**C. Factors for Evaluation**

The following factors shall be evaluated as part of the appointment and reappointment processes:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;
- (c) good reputation and character;
- (d) ability to safely and competently perform the clinical privileges requested;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

**D. No Entitlement to Appointment**

No one is entitled to receive an application or to be appointed or reappointed to the Medical Staff or Allied Health Professional Staff or to be granted particular clinical privileges merely because he or she:

- (a) is licensed to practice a profession in this or any other state;
- (b) is a member of any particular professional organization;
- (c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;

- (d) resides in the geographic service area of the Hospital; or
- (e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity; or
- (f) is board certified.

**E. Nondiscrimination**

The critical access hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

**F. Right of Indemnification**

The Hospital shall provide a legal related expense of any medical staff member that are incurred as a result of carrying out assigned administrative/medical staff duties which were performed in good faith, including peer review and credentialing activities.

## **ARTICLE V - ALLIED HEALTH PROFESSIONAL STAFF**

### **A. ALLIED HEALTH PROFESSIONAL STAFF**

#### **1. Qualifications**

The Allied Health Professional (AHP) Staff consists of licensed independent practitioners, advanced practice providers, and supervised dependent staff that satisfy the qualifications and conditions for appointment to the Allied Health Professional Staff. The Allied Health Professional 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 Professional Staff unless specifically limited to members of the Medical Staff.

#### **2. Prerogatives and Responsibilities**

Allied Health Professional Staff members with hospital privileges:

- (a) may attend applicable meetings (with vote);
- (b) may not hold office or serve as committee chairman;
- (c) may serve on a committee, if requested (with vote); and
- (d) must cooperate in the peer review and performance improvement process.

### **B. CONDITIONS OF PRACTICE APPLICABLE TO ALLIED HEALTH PROFESSIONAL STAFF**

#### **1. Oversight by Supervising Physician**

- (a) Advanced Practice Providers and Supervised Dependent Staff may function in the Hospital only so long as they have a Supervising Physician.
- (b) Any activities permitted to be performed at the Hospital by an Advanced Practice Provider or Supervised Dependent Staff will be performed only under the oversight of the Supervising Physician.
- (c) If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the Advanced Practice Provider or Supervised Dependent Staff fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician, the Advanced Practice Provider or Supervised Dependent Staff’s clinical privileges or scope of practice will be automatically relinquished, unless another Supervising Physician is approved as part of the credentialing process.
- (d) As a condition of clinical privileges or scope of practice, an Advanced Practice Provider or Supervised Dependent Staff and his or her Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the agreement between them. This notice must be provided to the IU Health White Memorial President within three days of any such change.
- (e) Advanced Practice Providers orders must be co-signed in the medical record by the supervising physician within 10 days.
- (f) 25% of the Advanced Practice Providers charts must be reviewed in the first year; in future years the percent of chart reviews is based upon the percent agreed upon by the Dr. and Advanced Practice Provider.

2. Questions Regarding the Authority of an Advanced Practice Provider or a Supervised Dependent Staff

- (a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an Advanced Practice Provider or Supervised Dependent Staff to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the Advanced Practice Provider or Supervised Dependent Staff. Any act or instruction of the Advanced Practice Provider or Supervised Dependent Staff will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges or scope of practice granted to the individual.
- (b) Any question regarding the conduct of an Advanced Practice Provider or Supervised Dependent Staff will be reported to the President of the Medical Staff, or the IU Health White Memorial President for appropriate action. The individual(s) to whom the concern has been reported will also discuss the matter with the Supervising Physician.
- (c) Allied Health Professional Staff privileges or scope of practice may be suspended summarily by agreement of any two of the following persons: President of the Medical Staff, Vice President of the Medical Staff, Secretary-Treasurer of the Medical Staff, or Hospital President;
- (d) An Allied Health Professional or the supervising physician may request an informal review of the summary suspension;
- (e) Final action concerning the summary suspension will be taken by the Medical Staff, subject to approval of the Board.

3. Responsibilities of Supervising Physicians

- (a) Physicians who wish to use the services of an Advanced Practice Provider or Supervised Dependent Staff in their clinical practice at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with these bylaws before participating in any clinical or direct patient care of any kind in the Hospital.
- (b) The number of Advanced Practice Providers or Supervised Dependent Staff acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will make all appropriate filings with the state regarding the supervision and responsibilities, to the extent that such filings are required.
- (c) It will be the responsibility of the Supervising Physician to provide, or to arrange for, and furnish evidence of professional liability insurance coverage for the Advanced Practice Providers or Supervised Dependent Staff in amounts required by the Board. The insurance must cover any and all activities of the Advanced Practice Provider or Supervised Dependent Staff in the Hospital and requires these individuals to act in the Hospital only while such coverage is in effect.

**C. GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ALLIED HEALTH PROFESSIONAL STAFF**

**1. Review of Need**

- (a) Whenever an Allied Health Professional requests to practice at the Hospital, and the Board has not already approved the category of practice at the Hospital, the Credentials Committee shall evaluate the need for that category. The committee shall report to the MEC, which shall make a recommendation to the Board for final action.
- (b) As part of the process of determining need, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, the reason access to the Hospital is sought, and the potential benefits to the community of having such services available at the Hospital.
- (c) The committee may consider the following factors when making a recommendation as to the need for the services of a specific category of Allied Health Professional Staff:
  - (1) the nature of the services that would be offered;
  - (2) any state license or regulation which outlines the specific patient care services and/or activities that the Allied Health Professional is authorized by law to perform;
  - (3) any state “nondiscrimination” or “any willing provider” laws that would apply to the Allied Health Professional;
  - (4) the patient care objectives of the Hospital, including patient convenience;
  - (5) the community’s needs and whether those needs are currently being met or could be better met if the services offered by the Allied Health Professional Staff were provided at the Hospital;
  - (6) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;
  - (7) the availability of supplies, equipment, and other necessary Hospital resources;
  - (8) the need for, and availability of, trained staff to support the services that would be offered; and
  - (9) the ability to appropriately supervise performance and monitor quality of care.

**2. Additional Recommendations**

- (a) If the committee makes a recommendation that there is a need for the particular category of Allied Health Professional Staff at the Hospital, it shall also recommend:
  - (1) any specific qualifications and/or training that must be possessed beyond those set forth in these bylaws;
  - (2) a detailed description of a scope of practice or clinical privileges;
  - (3) any specific conditions that apply to practice within the Hospital; and
  - (4) any supervision requirements, if applicable.
- (b) In developing such recommendations, the committee shall consult the appropriate specialty members and consider relevant Indiana law and may contact professional societies or associations. The committee may also recommend the number of Allied Health Professionals that are needed.

## ARTICLE VI - CLINICAL SERVICES

### A. ORGANIZATION OF MEDICAL STAFF

There shall be clinical departments of, including but not limited to, medicine, surgery, anesthesia, cardiopulmonary, emergency medicine, pathology and radiology. Each clinical department shall be assigned a liaison and shall operate under the Medical Staff (as a “committee of the whole”).

Each clinical department liaison will have overall responsibility for the Hospital's patient care functions in that department, including professional authority over the day to day activities of the patient care functions. Each such responsible Medical Staff member must have clinical privileges in the department he or she is responsible for.

### B. QUALIFICATIONS, SELECTION AND TENURE OF DEPARTMENT LIAISONS:

QUALIFICATIONS: Each department liaison will be a member of the Medical Staff. He or she shall be board certified in the specialty which he or she is assigned. If the department liaison is not board certified, he or she shall be qualified by education, experience, and demonstrated competency in that specialty.

APPOINTMENT: Each department liaison shall be appointed by the President of the Medical Staff for a one (1) year term, subject to approval of the Governing Body. Where feasible, the liaison should enjoy continuity of tenure so long as they are carrying out the duties and responsibilities provided for them in these Bylaws to the satisfaction of the members of their services, of the Medical Staff, and of the Governing Body.

REMOVAL: The department liaison may be removed during his or her term of office for dereliction of duty or failure to abide by the Bylaws. A two thirds (2/3) majority vote of all active Medical Staff members will be necessary to remove the department liaison during his or her term of office, and such removal shall not be effective unless and until it has been ratified by the Governing Body.

### C. RESPONSIBILITIES OF DEPARTMENT LIAISONS:

Each Liaison shall:

1. be accountable for all professional activities within his or her department;
2. give guidance on the overall medical policies of the Hospital and make specific recommendations and suggestions regarding his or her department in order to assure quality patient care;
3. maintain continuing review of the professional performance of all practitioners with clinical privileges in his or her department and report, when required, to the appropriate Committee;
4. be responsible for enforcement of the Hospital Bylaws and of the Medical Staff Bylaws, Rules and Regulations within his or her department;
5. be responsible for implementation within his or her department of actions taken by the Medical Staff;
6. transmit to the appropriate Committee his or her department's recommendations concerning the Staff classification, the reappointment and the delineation of clinical privileges for all

- Practitioners in his or her department;
7. participate in every phase of his or her department through cooperation with the Nursing Service and the Hospital Administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;
  8. assist in the preparation of such reports, including budgetary planning, pertaining to his or her department as may be required by the Medical Staff, the Administrator or the Governing Body; and
  9. be responsible for the care of patients in his/her clinical department if the attending Physician or Dentist cannot be reached.

**D. EVALUATION AND EDUCATION:**

1. The Medical Staff shall establish its own criteria, consistent with the policies of the Medical Staff and of the Governing Body, for the granting of clinical privileges in each division.
2. There shall be conducted a retrospective review of completed records of discharged patients and other pertinent sources of medical information relating to patient care that will contribute to the continuing education of every Practitioner and to the process of developing criteria to assure optimal patient care.
3. Such reviews shall include a consideration of all deaths, of patients with infections, complications, errors in diagnosis and treatment, of patients currently in the Hospital with unsolved clinical problems, of proper utilization of Hospital facilities and services, and of other significant patient care matters. The review of surgical matters shall also include a comprehensive tissue review for justification of 5% or 30 surgery cases performed, whichever is greater, whether tissue was removed or not, for acceptability of the procedure chosen, and for agreement or disagreement between the pre-operative and pathological diagnoses.
4. Tissue review procedure shall include the following categories:
  - c. Preoperative diagnosis was confirmed by the surgical pathology.
  - d. Preoperative and postoperative diagnoses were found incongruent, but the actual pathology correlated with the clinical course and removal was therefore justifiable.
  - e. No tissue was removed, such as in lysis of adhesions and in entero-enterostomies for mechanical bowel obstruction, or normal tissue removed by plan, such as in pyloroplasties for duodenal ulcer, and the clinical histories and documented findings justify the need for surgery.
  - f. The preoperative diagnosis and the surgical findings are not appropriately interrelated, and from the record it appears that surgery may not have been justified.

In addition to the medical care evaluation reports and the related Staff discussion, Staff members assigned to multi-disciplinary Hospital committees concerned with patient care matters should regularly report on the activities of these committees pertinent to the maintenance and improvement of high professional standards within the Hospital.

## ARTICLE VII - CLINICAL PRIVILEGES

### A. **Category Classification**

The applicant shall have the burden of establishing his or her qualifications and competency in the clinical privileges he or she requests. Clinical privileges must be delineated for every Practitioner (either by delineation of privilege forms or by scope of practice forms).

### B. **Admitting and Co-admitting Privileges**

1. Admitting Privileges. In order to be eligible for admitting privileges, a Practitioner must:
  - a. hold clinical privileges at the Hospital;
  - b. maintain an unlimited license in a profession which is authorized to diagnose and treat conditions which regularly require inpatient hospitalization because of the severity, complexity or risk factors associated with such conditions;
  - c. be licensed to perform a history and physical examination and to assume overall medical responsibility for a patient's care in the Hospital;
  - d. be authorized by law to prescribe and approve all medications used for patient diagnosis and treatment in the Hospital;
  - e. be authorized by law to assist or supervise any other category of Practitioner holding co-admitting privileges;
  - f. be authorized under Medicare, Medicaid, and commercial third-party payors to provide the Physician's certification of diagnosis and of medical necessity for all inpatient services connected with a patient's care; and
  - g. meet other conditions as are adopted by the Medical Staff and approved by the Board.
  
2. Co-admitting Privileges.
  - a. In order to be eligible for co-admitting privileges, a Practitioner must:
    - 1) hold clinical privileges at the Hospital;
    - 2) maintain an unlimited license in a profession which is authorized to diagnose and treat conditions which regularly require inpatient hospitalization because of the severity, complexity or risk factors associated with such conditions; and
    - 3) meet such other conditions as are adopted by the Medical Staff and approved by the Board.
  - b. Co-admitting privileges entitle a Practitioner to admit a patient to the Hospital for treatment within such Practitioner's area of licensure, subject to designating a member of the Active Staff with admitting privileges who will be responsible for the patient's medical evaluation, history and physical examination; the admitting Practitioner shall supervise and monitor the medical care of the patient other than the specific care pertaining to the co-admitting Practitioner's area of licensure.
  - c. A Practitioner who admits a patient with a co-admitting Practitioner does not accept responsibility of the care provided by the co-admitting Practitioner.

### C. **Temporary Privileges**

Under certain circumstances, temporary clinical privileges may be granted for a limited period of time. There are two circumstances in which temporary privileges may be granted. Each circumstance has different criteria for granting privileges. The circumstances for which the

granting of temporary privileges is acceptable are:

1. To fulfill an important patient care, treatment and service need;
  2. When an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the medical executive committee and the governing body (i.e. individual applying for clinical privileges at the critical access hospital for the first time (including locum tenens providers); an individual currently granted clinical privileges who is requesting one or more additional privileges; and an individual who is in the reappointment/re-privileging process and is requesting additional privileges.
- A. When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence (including current IN license, controlled substance registration, DEA, medical malpractice coverage and current clinical competence provided by current most active hospital, section chair or chief of staff).
  - B. Temporary privileges for applicants for new privileges may be granted while awaiting review and approval by the medical executive committee upon a completion of the medical staff credentialing process.
  - C. All temporary privileges are granted by the hospital president or authorized designee.
  - D. All temporary privileges are granted on recommendation of the medical staff president or authorized designee.
  - E. Temporary privileges are granted for no longer than 120 days.
  - F. Temporary privileges are extended as a matter of grace and confer upon the recipient no membership of the Medical Staff, no appointment as an Allied Health Professional, and no rights under these Bylaws.
  - G. Temporary privileges may be suspended, modified or revoked at any time by the hospital president or authorized designee without giving rise to the right to a hearing and appeal under these Bylaws.
  - H. Upon suspension and/or termination of temporary clinical privileges, the medical staff president shall have the power to assign another medical staff member to provide alternate medical care to the patients of the suspended or terminated Physician or Dentist, and/or to discharge such patients from the Hospital, as appropriate.

**D. Emergency Situations**

1. For the purpose of this section, an “emergency” is defined as a condition which could result in serious or permanent harm to patient(s) and in which any delay in administering treatment would add to that harm.
2. In an emergency situation, a member may administer treatment to the extent permitted by his or her license, regardless of service status or specific grant of clinical privileges.
3. When an emergency situation no longer exists, the patient shall be assigned by the department liaison or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

**E. Special Conditions for Dental and Podiatric Specialties**

1. Dentists

Dentists who are otherwise deemed qualified by the Medical Staff may admit patients if a Physician member of the Medical Staff conducts the admitting history and physical examination (except the portion related to dentistry). The Physician members shall assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization. Surgical procedures performed by Dentists and oral surgeons shall be under the supervision of a physician.

2. Podiatrists

a. General Podiatrists

Podiatrists who hold a DPM degree conferred by an approved school and who maintain an unlimited license from the Podiatric Licensing Board of Indiana may admit patients if a Physician member of the Medical Staff conducts the admitting history and physical examination (except the portion related to general podiatry). The Physician member shall assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization. Procedures performed by the podiatrist shall be under the supervision a physician.

b. Surgical Podiatrists

Podiatrists who have successfully completed an approved surgical training program and who have been granted surgical privileges by the Medical Staff may admit patients under the same provisions as for the general podiatrists. Surgical procedures performed by these podiatrists shall be under the supervision of a physician.

**F. Clinical Privileges for New Procedures:**

- (a) Requests for clinical privileges to perform either a procedure not currently being performed or a new technique to perform an existing procedure (“new procedure”) shall not be processed until a determination has been made that the procedure shall be offered by the Hospital and criteria for the privilege have been adopted.
- (b) The individual seeking to perform the new procedure shall submit a report to the appropriate committee addressing the following:
  - (1) minimum education, training, and experience necessary to perform the new procedure safely and competently;
  - (2) clinical indications for when the new procedure is appropriate;
  - (3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;
  - (4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
  - (5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and
  - (6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The appropriate committee shall review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered to the community.

- (c) If the preliminary recommendation is favorable, the appropriate committee shall then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the committee may conduct additional research and consult with experts, as necessary, and develop recommendations.
- (d) The committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action.

## ARTICLE VIII - APPOINTMENT AND REAPPOINTMENT

### GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

#### A. Basic Responsibilities and Requirements

As a condition of Medical Staff or Allied Health Professional Staff membership, every applicant and member specifically agree to the following, as applicable:

- (a) to provide continuous and timely care;
- (b) to abide by the bylaws, policies, and rules and regulations of the Hospital and Medical Staff and any revisions or amendments thereto;
- (c) to participate in Medical Staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;
- (d) to provide emergency call coverage, consultations, and care for unassigned patients;
- (e) to comply with applicable clinical practice protocols and guidelines or document the clinical reasons for variance;
- (f) to immediately submit to a blood, hair or urine test, or to a complete physical or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and the IU Health White Memorial President (or designee) are concerned about his or her ability to safely and competently care for patients. The health care professional(s) to perform the testing or evaluations shall be determined by the Medical Staff leaders;
- (g) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;
- (h) to use the Hospital sufficiently to allow continuing assessment of current competence;
- (i) to seek consultation whenever necessary;
- (j) to complete in a timely manner all medical and other required records;
- (k) to perform all services and to act in a cooperative and professional manner;
- (l) to promptly pay applicable fees; and
- (m) to satisfy continuing medical education requirements.

In addition to the above, every individual seeking to practice as a Dependent Allied Health Professional and his or her respective Collaborating/Supervising Physician specifically agree that:

- (a) any privileges granted by the Board to any non-physician Allied Health Professional Staff will be performed in the Hospital only under the supervision of a Supervising Physician;
- (b) the number of Allied Health Professionals employed by or under the supervision of a Member of the Medical Staff will be consistent with state law and the rules and regulations of the Medical Staff; and
- (c) an Allied Health Provider will give notice, within three days, to the Medical Staff Office, who will notify a Medical Staff Leader/Chair, of any revisions or modifications that are made to the supervisory agreement.
- (d) Additional supervision requirements are set forth in Appendix A.

**B. Burden of Providing Information:**

- (a) All applicants and members have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.
- (b) Applicants have the burden of providing evidence that all the statements made, and information given on the application are accurate and complete.
- (c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required shall be deemed to be withdrawn.
- (d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.
- (e) Notification of any change in status or any change in the information provided on the application form shall be given to the President of the Medical Staff. This information shall be provided with or without request, at the time the change occurs. Failure to provide this information shall deem the applicant ineligible for staff membership or clinical privileges. Failure to provide this information as a member shall result in automatic relinquishment.

**C. Provisional Period**

- (a) Initial appointment to the Medical Staff (regardless of the staff category), Allied Health Professional Staff, and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, shall be provisional.
- (b) During the provisional period, the numbers and types of cases to be reviewed as well as the exercise of clinical privileges shall be evaluated by the Credentials Committee. This evaluation may include a Focused Professional Practice evaluation (FPPE), chart review, monitoring, proctoring, external review, and other information, as determined by the Credentials Committee.
- (c) The duration of the provisional period for initial appointment and privileges shall be determined by the Credentials Committee.
- (d) During the provisional period, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed by the Credentials Committee or by other designated physicians.
- (e) A newly appointed member shall automatically relinquish his or her appointment and privileges at the end of the provisional period if he or she fails, during the provisional period, to:
  - (1) participate in the required number of cases;
  - (2) cooperate with the monitoring and review conditions; or
  - (3) fulfill all requirements of appointment, including but not limited to those relating to completion of medical records or emergency call responsibilities.

In such case, the individual may not reapply for initial appointment or privileges for *two years*.

- (f) If a member who has been granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases or cooperate with the monitoring and review conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period. The member may not reapply for the privileges in question for two years.
- (g) When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct, the member shall be entitled to a hearing and appeal.
- (h) If any requested privileges are denied by the Board, the applicant may reapply for those privileges only after a two (2) year waiting period. The waiting period shall begin upon the date of the Board's final decision.
- (i) Medical Staff membership category will be confirmed at the conclusion of the provisional period.

## **D. APPLICATION**

### **1. Information**

Applications for appointment and reappointment shall contain a request for specific clinical privileges or scope of practice and shall require detailed information concerning the applicant's professional qualifications. The applications for initial appointment and reappointment existing now, and as may be revised, are incorporated by reference and made a part of this document. The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

### **2. Misstatements and Omissions**

- (a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant shall be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The President of the Medical Staff shall review the response and determine whether the application should be processed further.
- (b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished if:
  1. discovery of a misstatement or omission on an application for initial appointment or reappointment, determined by the President of the Medical Staff and IU Health White Memorial President to be material and without good cause after considering any written or oral explanation provided by the individual;
  2. failure to notify the President of the Medical Staff or IU Health White Memorial President of any change in any information provided on an application for initial appointment or reappointment, determined by the President of the Medical Staff and IU Health White Memorial President to be material and without good cause after considering any written or oral explanation provided by the individual; or
  3. failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request specifying the time frame for response from the MEC, the IU Health White Memorial President, or any other committee authorized to request such information, until the information is provided to the satisfaction of the requesting party.
- (c) No action taken pursuant to this section shall entitle the applicant or member to a hearing or appeal.

### **3. Granting of Immunity and Authorization to Obtain/Release Information**

By applying for appointment, reappointment, or clinical privileges, the applicant accepts the following conditions throughout the term of appointment and thereafter as to any inquiries received about the applicant (also see the consent to release form):

(a) **Immunity**

To the fullest extent permitted by law, the applicant releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the applicant's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Medical Staff, the Hospital, its representatives, or third parties in the course of credentialing and peer review activities. The participant agrees not to sue any individuals for acts that are covered under the immunities set forth above.

(b) **Authorization to Obtain Information from Third Parties**

The applicant authorizes the Hospital, Medical Staff leaders, and their representatives (1) to consult with any third party who may have information bearing on the applicant's qualifications, and (2) to obtain any and all information from third parties that may be relevant. The applicant authorizes third parties to release this information to the Hospital and its representatives upon request. The applicant also agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(c) **Authorization to Release Information to Third Parties**

The applicant also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives when information is requested in order to evaluate his or her qualifications.

(d) **Hearing and Appeal Procedures**

The applicant agrees that the hearing and appeal procedures set forth in these bylaws shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) **Legal Actions**

If an applicant institutes legal action challenging any professional review action and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

(f) **Authorization to Share Information within the System**

The applicant specifically authorizes the Hospital and its affiliates to share information pertaining to the applicant's clinical competence or professional conduct.

(g) **Scope of Section**

All of the provisions in this Section D are applicable in the following situations:

- (1) whether or not appointment or clinical privileges are granted;
- (2) throughout the term of any appointment or reappointment period and thereafter;

- (3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and
- (4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff or Allied Health Professional Staff about his/her tenure at the Hospital.

**E. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES**

**1. Application**

- (a) Applications for appointment and clinical privileges shall be submitted to the CVO on forms approved by the Board, upon recommendation by the MEC.
- (b) Prospective applicants shall be sent a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.
- (c) An Allied Health Professional who is in a category of practitioners that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights set forth in this Policy. Such requests will be submitted to the Credentials Committee with recommendation to the Medical Executive and approval by the governing body.

**2. Initial Review of Application**

- (a) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 30 days after receipt. The application must be accompanied by the application fee, if applicable.
- (b) As a preliminary step, the application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.
- (c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information and confirming that all references and other information deemed pertinent have been received.
- (d) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current section chair at other health care entities, residency training program director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.
- (e) An interview(s) with the applicant may be conducted by one of or a combination of any of the following: The Credentials Committee, the MEC or representatives, the President of the Medical Staff, or the IU Health White Memorial President.

**F. Medical Staff Role**

In accessing the credentials of applicants, the Medical Staff shall act only as the agents of the Board. The Medical Staff shall make recommendations to the Board concerning applicant's

appointment to the Medical or as an Allied Health Professional as well as delineation of specific privileges for each applicant.

**G. Timetables**

The timetables for action upon applications, including hearings and appeals, shall be goals subject to good faith compliance and failure to comply with any such deadlines after good faith efforts have been made shall not give rise to any rights or causes of action deriving from these Bylaws.

**H. Credentials Committee Procedure**

- (a) The Credentials Committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant, and from other sources available to the Committee, whether the applicant has established and meets all of the necessary qualifications for the category of Staff or Allied Health Professional membership and for the specific clinical privileges requested by the applicant;
- (b) Where appropriate, as part of this process, the Credentials Committee may require an impartial physical or mental examination of the applicant and shall require that the results be made available for the Committee's consideration;
- (c) Within sixty (60) days after receipt of the completed application for privileges, the Credentials Committee shall make a recommendation on the applicant, including with its report the completed application and all other documentation considered in arriving at its recommendation;

The Credentials Committee **MAY** recommend:

- 1. that the Practitioner be appointed as a Medical Staff member or as an Allied Health Professional with certain specifically delineated privileges;
- 2. that he or she be denied Medical Staff membership or appointment as an Allied Health Professional;
- 3. that his or her application be deferred for further consideration within sixty (60) days; or
- 4. forwarding this information to the Medical Staff for final recommendation to the Board.

**I. Medical Staff Procedure**

- (a) When the recommendation of the Medical Staff is favorable to the applicant, the President of the Medical Staff shall promptly forward the written recommendation, together with all supporting documentation, to the Board. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such privileges.
- (b) When the recommendation of the Medical Staff is to defer the application for further consideration, it may be followed up within sixty (60) days with a subsequent recommendation for appointment to the Medical Staff or as an Allied Health Professional, with specified clinical privileges, or for denial of the application.
- (c) When the recommendation of the Medical Staff is adverse to the applicant in respect to either appointment or clinical privileges, the President of the Medical Staff shall promptly notify the applicant by certified mail, return receipt requested, or by personal delivery. The notice shall comply with the requirements set out in the Appendix A, Fair Hearing

Plan. The applicant shall be entitled to a hearing and appeal as set out in the Appendix A, Fair Hearing Plan. No such adverse recommendation shall be forwarded to the Board until after the Practitioner has exercised or has been deemed to have waived his or her right to a hearing and appeal.

- (d) If the Practitioner waives or is deemed to have waived his or her right to a hearing and appeal, the report and recommendation of the Medical Staff shall be forwarded to the Board for appropriate action. The Medical Staff's adverse recommendation shall remain effective pending final action by the Board, as provided in Appendix A, Fair Hearing Plan.

## J. **Governing Board Procedure**

The Board shall make all final decisions concerning appointments to the Medical Staff and granting of privileges to Allied Health Professionals. The Board shall make such final decisions after there has been a recommendation from the Medical Staff, as provided in these Bylaws, or after the Board has notified the Medical Staff and determined that the Staff has failed to act in a timely manner. The Board shall never be bound by the Medical Staff recommendations and shall always exercise its independent discretion as the ultimate peer review body of the Hospital. The Board may delegate certain medical staff oversight functions to the Board's Quality Committee (also known as the Quality Board) or other Board committees as it deems appropriate; provided, however, ultimate responsibility for such functions shall be retained by the Governing Board. Any final decision by the Board to grant, deny, revise, or revoke appointment or clinical privileges is disseminated to appropriate individuals and, as required, reported to appropriate entities.

### 1. **Eligibility for Reappointment**

- (a) All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment. In addition, to be eligible to apply for reappointment and renewal of clinical privileges, a member must have, as applicable:
  - (b) completed all medical records;
  - (c) completed all continuing medical education requirements;
  - (d) satisfied all Medical Staff or Allied Health Professional Staff responsibilities, including payment of any fees;
  - (e) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;
  - (f) paid any applicable reappointment processing fee; and
  - (g) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer), before the application shall be considered complete and processed further.

### 2. **Factors to be considered**

Each recommendation concerning the reappointment of a Practitioner and the granting of specific privileges, may be based upon the Practitioner's:

- (a) Medical Staff Bylaws and Rules & Regulations and Hospital Bylaws and policy

- compliance;
- (b) the results of the Hospital's performance improvement activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);
- (c) any focused professional practice evaluations; and
- (d) verified complaints received from patients or staff.

### **3. Reappointment Application**

- (a) Reappointment shall be for a period of not more than two years.
- (b) An application for reappointment shall be furnished by the CVO to practitioners at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the CVO within ninety (90) days.
- (c) Failure to submit a complete application within 90 days, may result in t automatic expiration of appointment and/or clinical privileges at the end of the current term of appointment.
- (d) If an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the Member's appointment and clinical privileges shall expire at the end of the current term of appointment. However, if the inaction is due to circumstances beyond the applicant's control, and no issues have been raised about the application, the IU Health White Memorial President and Board chairman may grant conditional reappointment for a period not to exceed 120 days to allow for Board action at its next meeting.
- (e) The application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.
- (f) The Medical Staff Office shall oversee the process of gathering and verifying relevant information. The Medical Staff Office shall also be responsible for confirming that all relevant information has been received.
- (g) The Credentials Committee shall follow the same process in assessing and recommending as they followed for initial appointment.
- (h) The MEC shall follow the same process in assessing and recommending to the Board as they followed for initial appointment.
- (i) If the MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the Chairman shall notify the member of the general tenor of the possible recommendation and may invite the member to meet prior to any final recommendation being made. Prior to this meeting, the member shall be notified of the general nature of the information supporting the recommendation contemplated. At the meeting, the member shall be invited to discuss, explain, or refute this information. A summary of the interview shall be made and included with the committee's recommendation. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The member shall not have the right to be represented by legal counsel at this meeting.

### **4. Conditional Reappointments**

- (a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., performance improvement steps such as general

consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of a member's compliance with any conditions that may be imposed.

- (b) A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.
- (c) In the event the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

## ARTICLE IX - CORRECTIVE ACTION FOR PRACTITIONERS

### A. Procedure

#### 1. Requests for Corrective Action.

Whenever the competence or professional conduct of any Practitioner who is a member of the Medical Staff and who has clinical privileges (other than Allied Health Professionals) is considered to not meet the applicable standard of care, or to be disruptive to the operations of the Hospital, corrective action against such Practitioner may be requested by any member of the Executive Committee, by the Administrator or by any member of the Board. All requests for corrective action shall be in writing, shall be made to the Executive Committee, and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request. Furthermore, the Board, acting as the Governing Body of the Hospital, can take corrective action or can decide to take corrective action without first seeking and/or obtaining a recommendation from the Executive Committee. However, if the Board so acts or decides to act without first seeking and/or obtaining a recommendation by the Executive Committee, the affected Practitioner shall be entitled to the applicable hearing and appeal rights set forth in Appendix A, Fair Hearing Plan, Section 5.1-6. The following are intended to be representative of issues which may generate such a request for corrective action:

- a. clinical competence;
- b. care of a particular patient or patients;
- c. violation of the Hospital Bylaws and policies, Medical Staff Bylaws, Rules and Regulations;
- d. violations of professional ethics as outlined by the code of ethics which govern his or her professional organization;
- e. the mental, emotional or physical health of the Practitioner;
- f. conduct disruptive or detrimental to the operation of the Hospital and/or patient care; or
- g. unauthorized release of peer review information.

#### 2. Medical Staff Review of Request

- a. The President of the Executive Committee shall promptly notify the Administrator in writing of all requests for corrective action and shall continue to keep the Administrator fully informed of all action taken concerning the request.
- b. After reviewing the request for corrective action, the Executive Committee may determine that:
  - 1) there is no evidence requiring corrective action and the Practitioner will be so informed;
  - 2) further investigation is needed and shall promptly appoint a single Ad Hoc Investigating Committee to investigate the matter under this Article, Section A., 3; or
  - 3) the action required is summary suspension, in which case the procedure under this Article, Section C shall be followed.

3. Ad Hoc Investigating Committee Procedure
  - a. The Practitioner shall have an opportunity for an interview with the ad hoc investigating committee. At such interview, he or she shall be informed of the general nature of the questions directed to him or her, and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A record of such interview shall be made by the Ad Hoc Investigating Committee.
  - b. Within thirty (30) days of its appointment, the Ad Hoc Investigating Committee shall make a report of its investigation to the Executive Committee **and** shall include the record of its interview with the Practitioner in its report.
  
4. Executive Committee Action
  - a. The Medical Staff will, within ten (10) days of receipt of the report of the Ad Hoc Investigating Committee:
    - 1) reject or modify the request for corrective action;
    - 2) issue a warning, a letter of admonition, or a letter of reprimand;
    - 3) order the review of the Practitioner's current and/or previous charting practices, and/or a review of the information reflected in such charts;
    - 4) impose terms of probation or a requirement for proctoring and/or consultation upon a provisional member of the Medical Staff;
    - 5) recommend requiring a non-provisional member of the Medical Staff to undergo proctoring or consultation;
    - 6) recommend reduction, suspension or revocation of clinical privileges;
    - 7) recommend the imposition of summary suspension as provided under Section C; and/or
    - 8) recommend that the Practitioner's Medical Staff membership be suspended or revoked.
  - b. The term "recommend" as used in subparagraph "a" above shall mean a recommendation to the Board. Any such recommendation by the Medical Staff to the Board for Staff action that could adversely affect the Practitioner's clinical privileges or membership on the Medical Staff, shall entitle the affected Practitioner to the procedural rights provided in Appendix A, Fair Hearing Plan.
  - c. Letters of admonition, warning or reprimand, imposition of required consultations, assistance or probation shall not be considered adverse action affecting privileges, shall not be reported to the Medical Licensing Board or to others making inquiry into a Practitioner's privileges and shall not give rise to the procedural rights provided by Appendix A, Fair Hearing Plan.

**B. Probation**

1. Probation may be imposed on a Practitioner who has clinical privileges. Probation is not punitive in nature, is not an adverse reflection on the Practitioner's skills or character, and may not constitute an adverse action, as defined. Probation is required when more specific, first-hand observation is needed to evaluate a Practitioner. Practitioners on probation will be observed by proctors assigned to them by the Executive Committee. Proctors are to evaluate the medical care provided by the Practitioner including, where appropriate, personal observation of diagnostic or surgical procedures, interpretation of diagnostic studies, and

consultations. Proctors may base their reports to the Executive Committee in part on medical care which they have personally observed at other hospitals.

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

**C. Summary Suspension**

1. The Staff membership and/or clinical privileges of a Practitioner may be suspended or limited when required to protect patients from potential future harm or to prevent disruption of the operation of the Hospital, by a peer review committee composed of:
  - a. any two of the following persons: The President, Vice President, Secretary-Treasurer of the Staff and/or the Administrator, or
  - b. the Executive Committee; or
  - c. the Board.
2. The Practitioner shall be informed immediately by the President of the Executive Committee or his or her designee, and the summary suspension shall be effective immediately upon imposition. The Administrator shall also be immediately informed of the summary suspension.
3. Immediately upon the imposition of a summary suspension, the President of the Staff or his or her delegate shall have authority to provide for alternative medical coverage for the patients of the suspended Practitioner still at the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of the alternate Practitioner.
4. The Practitioner shall be given prompt written notice of the reasons for the summary suspension by the Administrator. During the fourteen-day period after the imposition of the suspension, the suspension shall be a summary suspension as defined in these Bylaws.
5. During the summary suspension, the Executive Committee shall conduct an investigation to determine the need for a recommendation for adverse action. The suspended Practitioner shall be entitled to request an interview with the Executive Committee which shall take place during that fourteen-day period.
6. During the summary suspension, the Executive Committee may recommend continuance, modification, or termination of the summary suspension. If the suspension is terminated within fourteen (14) days of its imposition without further recommendation for adverse action, no right to a hearing and appeal shall arise unless a summary suspension has been imposed on the same Practitioner more than twice in a six-month period.

7. If the Executive Committee determines to continue the summary suspension beyond fourteen days, or recommends other adverse action, the Practitioner shall be given notice of such determination or recommendation by certified mail, return receipt requested, from the Administrator, in accordance with Appendix A, Fair Hearing Plan, Section 1(d). Other Practitioners shall have the opportunity to appear before the Executive Committee. The Practitioner shall have all of the rights to a hearing and appeal under the Fair Hearing Plan and shall be informed of his or her right to request an expedited hearing. The terms of the summary suspension as sustained and modified by the Executive Committee shall remain in effect pending final decision by the Governing Board.

**D. Automatic Suspension**

1. Delinquent Patient Charts

- a. A Practitioner's patient charts shall be deemed delinquent if not completed by the fifteenth day (15) following discharge of the patient. The medical records department shall issue an immediate warning to each Practitioner who has one or more delinquent charts. If a Practitioner fails to complete any delinquent charts within seven (7) days of warning, his or her Hospital admitting privileges shall be automatically suspended until all delinquent charts of his or her patients are completed.
- b. A Practitioner whose privileges are suspended because of delinquent charts may not admit patients under the name of another Practitioner. He or she may admit patients to another Practitioner whose admitting privileges are in good standing, with the prior approval of that Practitioner.
- c. Automatic suspensions due to delinquent records are to be imposed by written notice to the Practitioner, Administrator, President of the Staff, and admitting office, by the Director of Medical Records.
- d. A Practitioner may request in advance a waiver of these requirements for planned vacations or professional absences.

2. Suspended License

- a. Any limitation or suspension of a Practitioner's license to practice his or her profession by his or her licensing board and/or any limitation or suspension of a Practitioner's license to prescribe narcotic drugs shall automatically limit and/or suspend the Practitioner's Hospital privileges for the same period of time.
- b. Any such suspension shall be submitted to the Executive Committee and shall not be lifted until the suspension or limitation is lifted by the licensing board and privileges are reinstated by the Medical Executive Committee and Governing Board.

3. Failure to have Insurance or Pay Surcharge

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

4. Failure to Complete Continuing Education or Attend Meetings.  
Automatic suspensions may also be imposed for failure to complete any required number of hours of continuing medical education or for failure to attend required meetings of the Executive Committee or committees.
5. Effect of Automatic Suspension  
Automatic suspensions are not deemed adverse action and do not give rise to a hearing or appeal, are imposed by notice to the affected Practitioner by the medical records department, executive committee, or Administrator as appropriate, and are terminated by the Practitioner's compliance with the involved requirement except as provided specifically otherwise.

## ARTICLE X - IMMUNITY FROM LIABILITY

### A. **Conditions of Practitioner's Application for the Exercise of Privileges**

The following shall be express conditions to any Practitioner's application for, or exercise of, clinical privileges at this Hospital:

1. Any act, communication, report, recommendation, or disclosure, with respect to any Practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.
2. Such privilege shall extend to the Hospital corporation, members of the Hospital Medical Staff, its Board, its Administrator, and his or her agents and/or employees, and third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same.

For the purpose of this Article X, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Board or of the Medical Staff and all persons and organizations defined as "Personnel of a Peer Review Committees" by statute.

3. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.
4. Such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution's activities related to, but not limited to:
  - a. applications for appointment or clinical privileges;
  - b. periodic reappraisals for appointment or clinical privileges;
  - c. corrective action, including summary suspension;
  - d. hearings and appellate reviews;
    1. medical care evaluations;
    2. utilization reviews; and
    3. other Hospital, department or committee activities related to quality of patient care and interprofessional conduct.
5. The acts, communications, reports, recommendations, and disclosures referred to in this Article X include any related to a Practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly have an effect on patient care.
6. Each Practitioner shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Article X in favor of the individuals and organizations specified in paragraph 2 above, subject to such requirements, including those of good faith, absence of

malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.

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

## ARTICLE XI - DIVISIONS OF MEDICAL STAFF

The Medical Staff shall be divided into Active, Consulting, Courtesy and Honorary staff. A provisional period is required in the Active, Consulting and Courtesy staff divisions prior to being eligible for full Staff membership in the appropriate division.

### A. **Active Staff**

The Active Staff shall consist of Physicians and Dentists who are privileged to admit and treat patients in the Hospital and who perform a major part of their practice in White County or in immediate adjacent counties. The Active Staff is eligible to vote in meetings of the Medical Staff, hold elective office and serve on committees. Each member of the Active Staff shall be required to attend at least 70 percent of the regular staff meetings each year. The consequence of having more than three (3) absences will be the revocation of voting privileges at the Medical Executive Committee meetings for a period of one year or until the 70 percent meeting attendance has been achieved over the next year. All Active Staff members are required to pay an application fee (unless exempted), participate in the emergency service rotation (if applicable) and are encouraged to participate in formal medical education programs.

- Emergency Department Back-up Call: Reference policy *ADM 3.48 Emergency On-Call* for delineation of responsibilities associated with emergency and unassigned call.

### B. **Consulting Staff**

The Consulting Staff shall consist of Physicians and Dentists whose primary practice is not in the service area of the Hospital. The Consulting Staff shall be privileged to admit and treat patients in the Hospital but are not eligible to vote, hold elective office or serve on committees (unless requested by the MEC). A Consulting Staff member who admits twenty-five (25) patients or more per year may be assigned to the Active Staff upon recommendation of the Medical Staff, and approval by the Board. All Consulting Staff members are required to pay an application fee (unless exempted). Consulting Staff members are urged to attend meetings of the Medical Staff as well as participate in formal medical education programs, but these are not compulsory.

### D. **Courtesy Staff**

The Courtesy Staff shall consist of Physicians and Dentists who only occasionally admit or care for patients in the Hospital. The Courtesy Staff are not eligible to vote, hold elective office or serve on committees (unless requested by MEC). A Courtesy Staff member who admits more than twelve (12) patients per year may be assigned to the Active or Consulting Staff upon recommendation of the Medical Staff and approved by the Board. All Courtesy Staff members are required to pay an application fee (unless exempted). Courtesy Staff members are urged to attend meetings of the Medical Staff meetings as well as participate in formal medical education programs, but these are not compulsory.

### C. **Honorary Staff**

The Honorary Staff shall consist of Physicians and Dentists who do not actively practice in the Hospital. These may be Physicians or Dentists who have retired from active practice or who are recognized for their noteworthy contribution to patient care and/or their long-standing service to

the Hospital. Honorary Staff members shall not be eligible to admit or treat patients, assist in surgery, serve as alternates, vote, hold office or serve on standing Medical Staff committees. The Honorary Staff have no emergency service responsibility and are not required to pay any fees. Once a provider has been granted Honorary status, their status will not need further acknowledgement. Honorary status will discontinue upon the Physician or Dentists request, committee request, or notification of providers death.

E. **Procedure for Leave of Absence**

When a Physician or Dentist requests a leave of absence for a period of one (1) year or more for further education or military service or other reasons, he or she will be assigned to the Consulting Staff and shall maintain all previously approved clinical privileges, pending current review. On return, he or she may request change of staff status.

## **ARTICLE XII - HOSPITAL PHYSICIAN ASSISTANCE COMMITTEE**

### **A. POLICY STATEMENT**

To improve the quality of care and promote the competence of the Medical Staff, there is hereby established a Hospital Physician Assistance Committee (for purposes of this Article, referred to as the "Committee") pursuant to the Indiana Physician Practice Act and the regulations thereto within the Hospital. The Medical Staff of the Hospital hereby establishes the Committee as a peer review committee. This Committee is entirely independent of any other committee and entirely separate from any disciplinary or enforcement activities established or authorized by these Bylaws. Members of the Medical Staff, Hospital personnel or any other caring and interested persons must report to the Committee any suspected instances where there is a good faith basis to suspect functional and/or professional impairment of a member of the Medical Staff because of alcohol, drug dependence or mental, physical, emotional or aging problems that have or could give rise to the injury of a patient.

### **B. COMPOSITION**

The Committee shall be composed of the members as appointed by the Medical Staff President.

The Administrator shall be an ex-officio member. It is recommended that Practitioners have a minimum of three (3) years of recovery from an impairing illness before serving on the Committee.

### **C. DUTIES**

1. To be available to receive reports, anonymous or otherwise from all sources, including self-referral, regarding a potentially Impaired Physician and evaluate the credibility of a complaint, allegation, or concern;
2. To act as a liaison between this Committee and the Indiana State Medical Association Physician Assistance Committee ("ISMA")
3. To refer concerns/reports regarding the potentially Impaired Physician to ISMA when an intervention/treatment or referral/monitoring is necessary, as well as to the Executive Committee in instances where a Practitioner is providing unsafe treatment;
4. To be available to assist in gathering information on the potentially Impaired Physician and to assist, when needed, in the intervention and referral of the Impaired Physician to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;
5. To assist, when needed, on being monitors for the recovering Practitioner until the rehabilitation is complete;
6. To educate the Medical Staff and other organization staff about illness and impairment recognition issues specific to Practitioners;
7. To develop and adopt policies and procedures appropriate for dealing with Impaired Physicians; and
8. Other duties reasonably related to the scope of the Committee's authority.

D. **POLICIES**

All contacts of sources of information, including Practitioner contract, shall be confidential. Confidentiality of the Impaired Physician seeking referral or referred for assistance will be maintained except as limited by law, ethical obligation, or when the safety of a patient is threatened.

E. **MEETINGS**

The Committee shall meet as often as necessary. Minutes of the activities of the Committee shall be recorded but confidentiality will always be respected.

## ARTICLE XIII - OFFICERS

### A. **Officers of the Medical Staff**

1. The officers of the Medical Staff shall be:
  - a. President
  - b. Vice President, and
  - c. Secretary-Treasurer

### B. **Qualifications of Officers**

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

### C. **Election of Officers**

1. Officers shall be elected at November meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote.
2. The nominating committee shall consist of members of the Active Medical Staff appointed by the President of the Medical Staff. This committee shall offer one or more nominees for each office.
3. Nominations may also be made from the floor at this meeting.

### D. **Term of Office**

All officers shall serve either a two-year term or until a successor is elected. Officers shall take office on the first day of the Medical Staff year.

### E. **Vacancies in Office**

Vacancies in office during the Medical Staff year, except for the presidency, shall be filled by a member of the Executive Committee. If there is a vacancy in the office of the President, the Vice President shall serve out the remaining term.

### F. **Removal from Office**

An officer of the Staff may be removed during his or her term of office for dereliction of duty or failure to abide by the Bylaws. The majority of the voting members present at any Medical Staff meeting may ask for a mailed ballot to remove an officer of the Staff. To remove an officer of the Staff, it is necessary that two thirds (2/3) of the members eligible to vote to remove.

### G. **Duties of Officers**

1. President:

The President of the Medical Staff shall:

  - a. act in coordination and cooperation with the Administrator in all matters of mutual concern within the Hospital;
  - b. serve as Chairman of the Executive Committee;
  - c. call, preside at, and be responsible for the agenda of all general and Executive

- Committee meetings of the Medical Staff;
- d. serve as ex-officio member of all Medical Staff committees without vote;
  - e. assist in the enforcement of Medical Staff Bylaws, Rules and Regulations, in the implementation of sanctions where these are indicated, and in the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;
  - f. appoint committee members to all standing, special and multi-disciplinary Medical Staff committees;
  - g. represent the views, policies, needs and grievances of the Medical Staff to the Board and to the Administrator;
  - h. receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
  - i. be responsible for the educational activities of the Medical Staff;
  - j. be the spokesman for the Medical Staff in its external professional and public relations; and
  - k. be considered Chief of Staff of the Medical Staff of the Hospital.

2. Vice President:

In the absence of the President, he or she shall assume all the duties and have the authority of the President. He or she shall automatically succeed the President when the office of President becomes vacant.

3. Secretary-Treasurer:

The Secretary-Treasurer shall call Medical Staff meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to his or her office. He or she shall automatically succeed the Vice President when the office of Vice President becomes vacant.

## ARTICLE XIV - EXECUTIVE COMMITTEE

### A. **Membership**

The Executive Committee shall be a committee of the whole, including in its membership all voting members of the Medical Staff. The Administrator shall be an ex-officio member with no vote. The President of the Medical Staff shall serve as chairman. The President may appoint certain members of the Committee to direct certain functions of the Committee.

### B. **Meetings**

The Committee shall meet monthly, at least ten (10) times a year, and at other special meetings called by the President or three other committee members. Each member of the Active staff shall be required to attend at least seventy (70) percent of the regular staff meetings each year. The consequence of having more than three (3) absences will be the revocation of voting privileges at the Medical Executive Committee meetings for a period of one year or until the seventy (70) percent meeting attendance has been achieved over the next year.

### C. **Duties**

The Committee shall have several functions, including:

1. Executive Function - The executive function of the committee is to:
  - a. coordinate the activities and general policies of the Medical Staff;
  - b. form and implement policies of the Staff;
  - c. advise the Administration in matters pertaining to Staff issues;
  - d. advise the Board of the medical care given to patients in the Hospital;
  - e. provide that the Medical Staff is kept abreast of accreditation programs and informed of the accreditation status of the Hospital;
  - f. act as the chief peer review committee in reviewing and recommending to the Board all matters relating to appointments and reappointments, clinical privileges, competence and professional conduct of Practitioners, and corrective action; and
  - g. initiate and pursue corrective action and adverse action in accordance with these Bylaws and the Fair Hearing Plan, Appendix A; and
  - h. acts on the reports of services, departments and committees of the Medical Staff.
2. Credentials Function - The credentials function of the Committee shall be carried out by a Credentials Committee which shall include active Medical Staff members and the Chief Nursing Officer (or designee). These committee members shall be chosen by the President. Their function is to:
  - a. review and gather information concerning all applications and reapplications for privileges as Medical Staff members or Allied Health Professionals;
  - b. review and gather information concerning all applications;
  - c. review and recommend to the administration those outpatient diagnostic procedures available to persons other than Practitioners who are qualified health care providers under the Indiana Medical Malpractice Act;
  - d. serve as a review committee on suspension or terminations of any privileges;
  - e. and serve as an impaired physician's committee, pursuant to 844 IAC 5-1-2, by counseling and monitoring the progress of any Practitioner who voluntarily places

- him/herself under the supervision of the committee.
3. Quality Improvement/Patient Safety Function - The quality improvement/patient safety function of the committee is to:
    - a. Review and assess the quality and safety of care given to patients at the organization.
    - b. Recommend modifications of organizational procedures or individual privileges in order to improve the quality and safety of care and service provided to the patient.
    - c. Recommend corrective actions when indicated by the review of patient care.
    - d. Ensure follow-up on recommended modifications to evaluate how they are implemented and if the desired effect was achieved.
    - e. Assure that the Hospital Quality/Patient Safety program maintains compliance with regulatory agency requirements.
    - f. Provide effective management to prevent, reduce, identify and control infections in the organization or brought into the organization from the community, in accordance with the Indiana State Department of Health and regulatory agency standards.
    - g. Evaluate the quality and composition of the medical record for clinical pertinence and timely completion, make recommendations when indicated to improve the process.
    - h. Review and approve policies relating to the selection, distribution, handling, use and administration of drugs.
    - i. Approve drug formulary decisions including additions and deletions from formulary and therapeutic substitutions.
    - j. Review and approve drug protocols concerned with the use of experimental drugs.
    - k. Receive reports regarding adverse drug reactions and/or drug interactions.
    - l. Review data regarding Operative and Invasive Procedures with regards to preoperative and postoperative diagnosis, pathology's surgical specimen report.
    - m. Evaluate the appropriateness of use of blood and blood products and the adequacy of the transfusion services.
    - n. Receive reports regarding Mortality/Morbidity Reviews and assessment of those records that require physician review.
    - o. Evaluate code blue response by the Hospital staff and the outcomes of these interventions.
  4. Utilization Review Function - The utilization review function of the committee is to:
    - a. determine the medical necessity of Hospital admissions;
    - b. determine the medical necessity of duration of Hospital stays;
    - c. study Hospital utilization practices to determine the appropriateness of all phases of care;
    - d. recommend action based on its findings; and
    - e. follow-up on recommended action to determine its effectiveness.
  5. Bylaws Function - The Committee shall review and recommend changes in the Bylaws.
  6. Medical Education Function - The Committee shall provide continuing education for the Medical Staff and direct the professional library service.
  7. Risk Management Function - The Committee shall participate in the identification of general areas and activities of potential risk to patients and shall actively pursue the reduction of the

risk of injury in those areas and activities. This shall be done through close coordination and interactions with the Hospital Risk Management Team, and with close interaction with the heads of the various departments of the Hospital.

**D. Immunities and Confidentiality**

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

**E. Minutes**

Minutes of each meeting of the Committee shall be prepared, including attendance and the vote taken on each appropriate matter. The minutes shall be signed by the President and maintained in a permanent file. All records of peer review matters shall be maintained in a confidential file available for inspection by Committee members, but such records may not be copied or circulated.

## **ARTICLE XV - MEDICAL STAFF MEETINGS**

### **A. Regular Meetings**

The regular meetings of the Medical Staff shall be held at the Hospital on the second Wednesday of each month at least ten (10) times a year at noon unless changed by the President. Election of officers shall be held at a regular meeting of the Medical Staff during the last quarter of each year.

### **B. Special Meetings**

1. The President or one-fourth of the Executive Committee may call a special meeting of the Medical Staff at any time. The President shall call a special meeting within fifteen days after receipt by him or her of a written request for same signed by not less than one-fourth of the Active staff and stating the purpose for such meeting. The President shall designate the time and place of any special meeting.
2. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, to each member of the Medical Staff not less than five nor more than ten days before the date of such meeting, by or at the direction of the President or other persons authorized to call the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

### **C. Quorum**

The presence of fifty percent (50%) of the total membership of the Active Medical Staff at any regular or special meeting shall constitute a quorum, with a simple majority vote for all actions.

### **D. Attendance Requirements**

Each member of the Active staff shall be required to attend at least seventy (70) percent of the regular Staff meetings each year. The consequence of three (3) absences will be the revocation of voting privileges at the Medical Executive Committee meetings for a period of one year or until the seventy (70) percent meeting attendance has been achieved over the next year.

### **E. Minutes**

Minutes of each regular and special meeting of the Medical Staff shall be prepared and shall include the attendance and the vote taken on each appropriate matter. The minutes shall be signed by the President and maintained in a permanent file. All records of reported peer review matter shall be maintained in a confidential file available for inspection by all members of the Medical Staff, but such records may not be copied or circulated, except as authorized by the Medical Staff President.

## **ARTICLE XVI - RULES AND REGULATIONS**

The Staff shall adopt Rules facilitating the work of the Hospital and the Rules hereinafter stated shall be in force with the adoption of these Bylaws. The Medical Staff, in cooperation with the Administrator, is empowered to institute or change Rules, with approval by the Board.

These Bylaws shall be reviewed not less than annually and shall take into consideration Indiana State Department of Health Regulations, regulatory agency standards and Indiana laws with respect to the operation of a county hospital.

## **ARTICLE XVII - ADOPTION OF AMENDMENTS TO BYLAWS**

These Bylaws may be amended by submitting the proposed amendment in writing to the Medical Staff for their consideration. Such proposal for amendment shall be mailed promptly to each voting member to be voted upon at the regular Medical Staff meeting the following month, or at a called meeting.

The affirmative vote of two-thirds (2/3) of the voting membership present shall be required for adoption. Amendments so made shall be effective when approved by the Governing Board.

## **ARTICLE XVIII - AUTHORITY**

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

**APPENDIX A**

**FAIR HEARING PLAN**

# **APPENDIX A - FAIR HEARING PLAN FOR THE MEDICAL STAFF OF INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL**

## **PREAMBLE**

The Governing Board for Indiana University Health White Memorial Hospital, and the Medical Staff and any committees thereof, in order to conduct Peer Review Activity, hereby constitute themselves as a Peer Review Committee as defined herein and as defined by the Indiana Peer Review Act and the Health Care Quality Improvement Act of 1986. Such committees hereby claim all privileges and immunities afforded to them by said federal and state statutes. The purpose of this Fair Hearing Plan ("Plan") is to provide a mechanism through which a fair hearing and appeal might be provided to Practitioners, as defined in the Bylaws, having privileges and/or membership on the Medical Staff or applying for privileges and/or membership on the Medical Staff. This Plan is intended to comply with the Health Care Quality Improvement Act of 1986 and the Indiana Peer Review Act. As such, any action taken pursuant to this Plan shall be in the reasonable belief that such was in the furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care in the Hospital), taken only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any Practitioners involved, and only in the reasonable belief that the action was warranted by the facts known after a reasonable effort has been made to obtain the facts.

### **1.1 GENERAL PROVISIONS**

#### **1.1-1 Exhaustion of Remedies**

If action is taken, decided or recommended that, as defined in Paragraph 11 in the "Definitions" section of the Bylaws, could adversely affect a Practitioner's clinical privileges or membership on the Medical Staff, the Practitioner must exhaust the remedies and/or procedures afforded by the Bylaws and this Plan before resorting to legal action.

#### **1.1-2 Substantial Compliance**

Technical or insignificant deviations from the procedures set forth in the Bylaws and this Plan shall not be grounds for invalidating the action taken.

### **2.1 GROUNDS FOR HEARING**

#### **2.1-1 Actions That Constitute Grounds for Hearing**

Only those actions or recommended actions expressly set forth in the Bylaws as giving rise to hearing and/or appeal rights constitute grounds for a hearing and/or appeal.

### **3.1 REQUESTS FOR HEARING**

#### **3.1-1 Notice of Action or Proposed Action**

In all cases in which action has been taken, decided or recommended that constitutes grounds for a hearing and/or appeal under this Plan as allowed pursuant to the Bylaws, the affected or potentially affected Practitioner shall be promptly given written notice, via certified mail, return receipt requested, that provides the following:

- (a) (i) that an action that could adversely affect his/her clinical privileges or membership on the Medical Staff has been taken, decided or recommended against him/her;
- (ii) the reasons for such action;
- (iii) that the Practitioner has a right to request a hearing on such action;
- (b) the Practitioner shall be given a time limit of not less than thirty (30) days within which to request such a hearing; and
- (c) the Practitioner shall be provided with a summary of the hearing rights of the Practitioner under this Plan.

3.1-2 Time to Request Hearing and Waiver

Unless otherwise specified, the Practitioner must make his/her request for a hearing in writing to the Board via the Administrator within thirty (30) days from receipt of or refusal to accept the notice advising him/her of the action taken, decided or recommended against him/her. The failure of the Practitioner to request a hearing to which he/she is entitled pursuant to the Bylaws and this Plan within the time and in the manner herein provided shall be deemed a waiver of his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled on the matter. The failure of the Practitioner to request an appellate review to which he/she is entitled within the time and in the manner provided shall be deemed a waiver of his/her right to such appellate review on the matter.

3.1-3 Notice of Time and Place for Hearing

Upon receiving a request for hearing, the President, or his/her designee, shall schedule and arrange for a hearing. He/She shall give written notice to the Practitioner of the place, time and date of the hearing. The date of the commencement of the hearing shall not be less than thirty (30) days, from the date the Practitioner receives the notice of hearing, provided however that when the request is received from a Practitioner who has been summarily suspended the hearing shall be expedited and held as soon as the arrangements may reasonably be made.

3.1-4 Notice of Charts, Reasons and Witnesses

As part of, or together with, the notice of the time and place of the hearing, the Practitioner, shall be provided with a written explanation of the reasons for the action taken, decided or recommended against him/her. Such notice shall also include a list of any charts being questioned. In addition, the notice shall include a written list of the names and addresses of the individuals so far as is then actually anticipated who will give testimony or evidence in support of the action that is the subject of the requested hearing. The witness list shall be amended as additional witnesses are identified, and each party shall provide the other with a final list of witnesses at least fifteen (15) days prior to the hearing.

3.1-5 The Judicial Hearing Committee Addressing Recommendations by the Medical Executive Committee

The President of the Board, or his/her designee, shall use their best efforts to appoint a Judicial Hearing Committee of three (3) members of the Medical Staff. No person who has actively participated in the prior consideration of the action recommended against the Practitioner or who is in direct economic competition with the Practitioner, or is an impartial peer such as individuals with blood relationships, employer/employee relationships, or other potential conflicts that might prevent the individual from giving an impartial assessment, or give the appearance for the potential of bias for or against the subject of the Peer Review shall be appointed a member of the Judicial Hearing Committee; however, knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Hearing Committee. In the event that it is not feasible to appoint a Judicial Hearing Committee from the Active Medical Staff, the Judicial Hearing Committee may be appointed from other Staff categories or Practitioners who are not Physicians or Dentists of the Medical Staff provided that such Physicians or Dentists shall be granted Courtesy Staff membership by the Administration on an expedited basis. The President of the Board, or his/her designee, shall appoint one (1) of the three (3) members of the Judicial Hearing Committee to serve as Chairman of the Judicial Hearing Committee.

3.1-6 The Judicial Hearing Committee Addressing Actions Taken or Decided by the Governing Board

The appointment of a Judicial Hearing Committee shall be made pursuant to and as anticipated by Section 5.1-6 of this Plan. The President of the Board, or his/her designee, shall appoint one (1) of the members of such Judicial Hearing Committee to serve as Chairman of such Committee.

3.1-7 Presence of Practitioner

No hearing shall be conducted without the presence of the Practitioner for whom the hearing has been scheduled unless he/she expressly waives such appearance or fails to appear for the hearing after appropriate notice. A Practitioner who fails without good cause to appear and proceed at such hearing in an efficient and orderly manner shall be deemed to have waived his/her rights to a hearing and to have voluntarily accepted the action taken, decided or recommended against him/her, and such action shall immediately become effective, or remain in effect upon adoption by the Board.

3.1-8 Postponement, Recess, Adjournment, Executive Session

Postponements of the hearing beyond the time set forth in the Bylaws shall be made in the sole discretion of the Chairman of the Judicial Hearing Committee, or the Hearing Officer if one was appointed. Granting of such postponements shall only be for good cause shown.

The Chairman or the Judicial Hearing Committee or the Hearing Officer may, without prior notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Judicial 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.

**4.1 HEARING PROCEDURE**

4.1-1 Prehearing Procedure

Neither side has any right to depose witnesses or to discovery of documents or other evidence in advance of the hearing. The Hearing Officer or, if none is appointed then the Chairman of the Judicial Hearing Committee, shall encourage the parties to exchange documents prior to the hearing and may require advance disclosure and limit introduction of any documents not provided to the other side in a timely manner.

It shall be the duty of the Practitioner and the body whose action is the subject of the hearing, or their respective designees, to exercise reasonable diligence in notifying the Hearing Officer or, if one is not appointed the Chairman of the Judicial Hearing Committee, of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

4.1-2 Representation

The hearing provided for in the Bylaws is for the purpose of inter-professional resolution of matters bearing on professional conduct, professional competency, or character. The Practitioner and the body whose action is the subject of the hearing

may be represented in any phase of the hearing by an attorney at law. In the absence of legal counsel, the Practitioner shall be entitled to be accompanied by and presented at the hearing by a person of his/her choice. The legal counsel or representatives may present materials supporting their respective positions, examine witnesses, and respond to appropriate questions.

4.1-3 Hearing Officer

The President of the Board, or his/her designee, may appoint a Hearing Officer who shall preside over the hearing, 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, rule on challenges and objections, and maintain decorum. The Hearing Officer may not act as a prosecuting officer or as an advocate. If the Hearing Officer is an attorney, he or she may participate in the deliberations of the Judicial Hearing Officer may be an attorney at law, but the Hospital's General Counsel shall not be eligible to serve as Hearing Officer.

4.1-4 Presentation of the Action Taken, Decided or Recommended

The Medical Staff, when its recommendation is the subject of the hearing, shall appoint a member of the Medical Staff to present its recommendation at the hearing. The Governing Board, when its action is the subject of the hearing, shall appoint one of its members to present it at the hearing. The presenter may rely upon the Hospital's legal counsel for the purpose of advising him/her; presenting evidence in support of the action taken, decided or recommended; examining witnesses and maintaining a proper record in the hearing.

4.1-5 Record of the Hearing

A record of the hearing proceedings shall be accurately and completely recorded. The cost of the recording shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Hearing Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

4.1-6 Rights of the Parties

At a hearing both sides shall have the following rights:

- (a) To ask Judicial Hearing Committee members questions which are directly related to whether the members are impermissibly biased and, if so, to challenge such members. Written notice of the intent to ask such questions of the Judicial Hearing Committee members shall be presented to the Chairman of the Judicial Hearing Committee, or the Hearing Officer, at least seven (7) days prior to the date of the hearing, or any objection to the composition of the Judicial Hearing Committee is waived;
- (b) To be represented by an attorney or other person of choice;
- (c) To call, examine and cross-examine witnesses;
- (d) To present relevant evidence regardless of its admissibility in a court of law; and

(e) To submit a written statement prior to, during, or at the close of the hearing.

The Practitioner may be called by the body whose action prompted the hearing and examined as if under cross-examination. Each party has the right to submit a written statement in support of his/her position and the Judicial Hearing Committee may request such a statement to be filed following the conclusion of the presentation of oral testimony.

4.1-7 Miscellaneous Rules

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to relying on the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The scope of cross-examination of witnesses shall not unreasonably exceed the scope of the direct examination of that witness, except as provided in Section 4.1-6.

The Judicial Hearing Committee may question the witnesses or call additional witnesses if it deems such action appropriate. The Judicial Hearing Committee will permit both sides to file written arguments.

4.1-8 Burdens of Going Forward and Burden of Proof

At any hearing involving the denial of Medical Staff membership or requested privileges, it shall be incumbent upon the Practitioner to come forward with evidence in support of his/her position. In all other cases, the body whose action prompted the hearing shall have the duty to initially come forward with evidence in support of such action. Thereafter, the burden shall shift to the Practitioner to produce evidence in support of his/her position. In all cases, the Practitioner shall bear the ultimate burden of persuading the Judicial Hearing Committee, by a preponderance of the evidence provided at the hearing that the reasons for the action lacked foundation in fact or that such action was otherwise arbitrary or unreasonable.

4.1-9 Adjournment and Conclusion

After consultation with the Chairman of the Judicial Hearing Committee, the Hearing Officer, if one is appointed, may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted and due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence or receipt of closing written arguments, if requested, the hearing shall be closed.

4.1-10 Basis for Decision

The recommendation of the Judicial Hearing Committee shall be based on the evidence introduced at the hearing including all logical and reasonable inferences from the evidence and the testimony. The decision of the Judicial Hearing Committee shall be subject to the rights of appeal or review as described in the Bylaws.

4.1-11 Recommendation of the Judicial Hearing Committee - Generally

Within ten (10) days after the final adjournment of the hearing, the Judicial Hearing Committee shall make a written report and recommendation and shall forward it and all other documentation to the body (either the Medical Staff or to the Board) whose action was the subject of the hearing. The report may recommend confirmation, modification, or rejection of the subject action taken, decided or recommended by said body.

4.1-12 Medical Staff's Review of Judicial Hearing Committee's Report & Recommendation

With respect to reports and recommendations of a Judicial Hearing Committee submitted to the Medical Staff, the Committee shall, at its next regular meeting after receipt of the Judicial Hearing Committee's report and recommendation, consider said report and recommendation and make its final recommendation to the Governing Board. In making this final recommendation, the Medical Staff shall be guided by the following principles:

- (a) Such recommendation must be based on the reasonable belief that the action so recommended is in furtherance of quality health care and, in this regard, interference with Hospital operations shall be deemed to constitute a matter affecting, involving and relating to quality health care and its provision at the Hospital;
- (b) Such recommendation must be the result of a reasonable effort to obtain the facts of the matter at issue;
- (c) Such recommendation must be made after adequate notice and hearing procedures have been afforded to the Practitioner involved or after such other procedures as are fair to the Practitioner under the circumstances and, in this regard, substantial compliance with the Bylaws and this Plan shall be deemed to afford the Practitioner such adequate notice and hearing procedures; and
- (d) Such recommendation must be based upon the belief that the action so recommended is warranted by the facts known after a reasonable effort has been undertaken to obtain facts regarding the matter at issue, and to afford the Practitioner adequate notice and hearing procedures pursuant to (c) above. With respect to the reasonableness of the effort to obtain facts regarding the matter at issue, substantial compliance with the Bylaws and this Fair Hearing Plan shall be deemed to constitute such reasonable effort.

The President of the Medical Staff shall provide a copy of the final recommendation to the Practitioner within ten (10) days of such Medical Staff final recommendation.

If the recommendation is adverse to the Practitioner, he/she shall have the right to an appellate review by the Board, or a committee thereof, as provided in Article 5.1.

- 4.1-13      Consideration of a Judicial Hearing Committee's Report and Recommendation Concerning an Action Taken or Decided by the Governing Board  
The consideration of a Judicial Hearing Committee's report and recommendation concerning an action taken or decided by the Board shall be undertaken in the manner set forth in Section 5.1-6 of this Plan. The Hearing Officer or, if none is appointed, the Chairman of the Judicial Hearing Committee, shall provide a copy of the Judicial Hearing Committee's report and recommendation to the Practitioner within ten (10) days after the final adjournment of the hearing. If the Judicial Hearing Committee's report and recommendation is adverse to the Practitioner, he/she shall be entitled to an appellate review to the extent provided for in Section 5.1-6 of this Plan. Such an appellate review, if any, shall not be governed by Sections 5.1-1 through 5.1-5 of this Plan unless expressly Hearing Plan.

## **5.1 APPEAL TO THE GOVERNING BOARD**

- 5.1-1      Request for Appellate Review of Recommendations Made by the Medical Staff under Section 4.1-12  
Practitioner, or within ten (10) days of his/her refusal to accept notice, of an adverse recommendation made or adhered to after a hearing as anticipated in Section 4.1-12, the Practitioner may, by written notice to the President of the Board, request an appellate review of the Medical Staff's recommendation by the Board. The Board may consider the appeal, or the President of the Board may appoint an Ad Hoc Appeal Committee of not less than three (3) persons who need not all be Board members to consider the appeal. Members of this Ad Hoc Appeal Committee considering the appeal shall not be in direct economic competition with the Practitioner.

The same right to appeal a recommendation of the Medical Staff is given to the Medical Staff officer, the clinical department/service chairperson or director, and/or the member of the Hospital administration who initiated the action at issue.

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be limited to the following:

- (a) substantial non-compliance with the procedures required by the Bylaws or this Plan, or applicable law, which has created demonstrable unfairness;
- (b) that the final recommendation of the Medical Staff was arbitrary, capricious or unreasonable and not supported by substantial evidence based upon the hearing record or such additional information as could not have been made available to the Judicial Hearing Committee during the hearing process in the exercise of reasonable diligence.

5.1-2 Written Statements

The Practitioner shall submit a written statement in his/her own behalf, in which those factual and procedural matters with which he/she disagrees, and his/her reasons for such disagreement shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted by the Practitioner to the Board by certified mail, return receipt requested, within ten (10) days from the date of the Practitioner's request for appellate review. A similar statement may be submitted by the Medical Staff and, if submitted, the President of the Board, or his/her designee, shall provide, by personally delivering or by certified mail, return receipt requested, a copy thereof to the Practitioner at least two (2) days prior to the date of such appellate review.

5.1-3 Time, Place and Notice

When an appellate review is requested, the Board shall timely, schedule and arrange for an appellate review. The Board shall give the Practitioner notice of the time, place, and date of the appellate review. The date of the appellate review shall be not less than fifteen (15) nor more than ninety (90) days from the date of receipt of the request for appellate review. However, if a Practitioner is under suspension, the appellate review shall be held as soon as the arrangements may reasonably be made. The time for the appellate review may be extended for good cause by the Board, or the Ad Hoc Appeal Committee (if any). In no case shall the appeal occur less than within five (5) days after both parties are provided a copy of the record.

5.1-4 Appeal Procedure

The proceeding before the Board or before the Ad Hoc Appeal Committee as anticipated by Section 5.1-1 of this Plan shall be in the nature of an appellate hearing based upon the record of the hearing of the Board of Directors or the Ad Hoc Appeal Committee may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Hearing Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing before the Judicial Hearing Committee. Each party shall have the right to be represented by legal counsel in connection with the appeal and to present a written statement in support of his/her position of the appeal. In its sole discretion, the Board or the Ad Hoc Appeal Committee may allow each party or representative to personally appear and make oral argument. The Board or the Ad Hoc Appeal Committee may thereafter conduct, at a time convenient to itself, deliberations outside the presence of the appellant, respondent, and their representatives. The ad Hoc Appeal Committee shall present to the Board its written report and recommendation as to whether the Board should accept, reject or modify the final recommendation of the Medical Executive Committee.

5.1-5 Final Decision by the Governing Board

Before or at its next regular meeting after the conclusion of the appellate review, the Board shall make its final decision and shall within ten (10) days, send notice

thereof to the Medical Staff and to the affected practitioner. The decision of the Board shall be final and shall be immediately effective.

5.1-6 Action Taken or Decided by the Board Not Based on a Recommendation of the Medical Staff

As provided for in the Bylaws, the Board can, without first obtaining or seeking a recommendation from the Medical Staff or otherwise in the absence of an adverse recommendation by the Medical Staff, take action or decide to take action that adversely affects or could adversely affect a Practitioner's clinical privileges and/or membership on the Medical Staff. If such action is taken or decided, the Board shall Hearing Plan. When any Practitioner receives notice of such action taken or decided by the Board that will adversely affect his/her clinical privileges or membership on the Medical Staff, and such action was taken or decided without first seeking or obtaining a recommendation from the Medical Staff or was otherwise taken or decided in the absence of an adverse recommendation by the Medical Staff, the affected practitioner shall be entitled to a hearing and appellate review pursuant to the Bylaws and this Section 5.1 of this Plan. The Practitioner shall be entitled to a hearing before a Judicial Hearing Committee comprised of three (3) members of the Board and three (3) members of the Medical Staff. The President of the Board shall appoint the Board's representatives to the Committee and the President of the Medical Staff shall appoint the Medical Staff's representatives to the Committee. No person who has actively participated in the action that is the subject of the hearing or who is in direct economic competition with the affected Practitioner shall be appointed to the Committee.

The Judicial Hearing Committee anticipated by this Section shall conduct a hearing if timely requested by the Practitioner pursuant and subject to the provisions of Section 3.1-2 of this Plan. Such hearing shall be conducted in accordance with procedures set forth in Sections 3.1-3; 3.1-4; 3.1-6 through 3.1-8; r.1-1 through 4.1-11 and 4.1-13. The Judicial Hearing Committee shall submit its report and recommendations directly to the Board for review and final action. Appellate review of an adverse report or recommendation by such Judicial Hearing Committee shall be permitted under such conditions as may be prescribed by the Board.

5.1-7 Further Review

Except when the matter is remanded for further review and recommendation, the final decision of the Board following the appeal procedures set forth in this Plan shall be effective immediately and shall not be subject to further review. If the matter is remanded to the Judicial Hearing Committee or any other body or person, said committee, body, or person shall promptly conduct its review and make its recommendations back to the Board in accordance with any instructions given by the Board. The time for a further review and report shall not exceed ninety (90) days, except as the parties may otherwise stipulate.

5.1-8 Right to One Hearing

No Practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of an action taken, decided or recommended.

5.1-9 Documentation of Disciplinary Action and Corrective Action

Actions taken to correct problems related to disciplinary action shall be documented within the Practitioner's file. Practitioners may submit evidence to be included in their file as documentation of corrective action. Lifting of disciplinary actions, as recommended by the Medical Staff Executive Committee and approved by the Board, must also be documented.

Board approval: 5.17.17, 5.16.18, 8.15.18, 5.23.18

MEC approval: 8.16.19